HEALTH AND EMPOWERMENT : A SOCIOLOGICAL STUDY OF MUSLIM WOMEN IN NORTH INDIA

DISSERTATION

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IN

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By

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Dedicated

To

My

Beloved Parents

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Certificate

This is to certify that **Ms. Shazia Naseer**, has worked under my supervision for her M. Phil Dissertation on the topic ***Health and Empowerment: A Sociological Study of Muslim Women in North India***. She has completed all the necessary requirements prescribed in the academic ordinances and her research work is original and suitable for the submission for the award of M. Phil Degree in Sociology.

04/09/09

(Dr. Mohammad Akram)

SUPERVISOR

PREFACE

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the "absence of disease". In some cultures, health and harmony are considered equivalent, harmony being defined as "being at peace with the self, the community, god and cosmos".

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a world-wide social goal; that it is essential to the satisfaction of basic human needs and to an improved quality of life; and that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that the main social target of governments and WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", for brevity, called "Health for All".

India has made considerable progress in social and economic development in recent decades, as improvement in indicators such as life expectancy, infant mortality, and literacy demonstrate. However, improvements in women's health, particularly in the North, have lagged behind gains in other areas. The condition of women's health is poorer than men. The socially constructed differences between women and men lead to the discrimination against women even before the birth. Women are often seen as having lower status. Yet, women bear the entire burden of childbearing and child rearing.

The present study is entitled "Health and Empowerment: A Sociological study of Muslim women in North India". it is the study of the Muslim women of northern India, with special reference to the aspects of health and empowerment. For this study, I have referred to various books, journals and magazines and certain websites.

The research work is divided in four chapters. The first chapter "Health and Empowerment" deals with the concept of health and empowerment, indicators,

dimensions and relationship between health and empowerment. The second chapter "Muslims in India (A general profile with reference to women)", explains the social, political, economic and health conditions of Muslims in general and Muslim women in particular in North India. The third chapter "Health condition of Muslim women in North India" deals with the health problems faced by Muslim women related to female mortality and morbidity, disease burden, reproductive health and reproductive behaviour, contraception, abortion, maternal mortality and morbidity, gynecological morbidity and infertility, nutrition, and some health problems related to nature of women's productive work; and violence against women and its consequences for the health care system of women.

The fourth chapter "Interface between health, Reproductive health and Empowerment of Muslim women" concludes that Muslim women, like most women all over the world suffer similar problems particularly in relation to their sexual and reproductive health rights such as: Maternal mortality and morbidity due to pregnancy and childbirth; contraceptive use; access to safe, legal abortion; safe, consensual and satisfactory sexual relations; domestic violence and sexual coercion; contraction of STIs and HIV/AIDS. Empowerment is one of the tried and tested strategies for attaining gender equality. There is constitutional mandate to deal with different dimensions of equality for women in India. Constitution clarifies that affirmative action for women is compatible with the principles of non-discrimination on the ground of sex. India has also ratified various international conventions and human rights instruments committing to secure equal rights for women. Women lag behind men in most of the critical indicators of human development and poverty among women is on the rise. Women have a subordinate status in almost every sphere of life. Efforts of the Government, however, primarily revolve around economic empowerment and relatively less in the field of social empowerment. Women are exposed to major health risks due to their reproductive roles.

This dissertation tries to look at the issues related to health and empowerment of Muslim women in North India under these circumstances. The work is based on secondary information and mainly related to review of authentic work

available. However, one specific problem faced by the work is scarcity of available work related to health and empowerment of Muslim women.

Shazia Naseer

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Shazia Naseer

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ABBREVIATIONS

ADEA	Association For the Development of Education in Africa
AIWC	All India Women's Conference
AIDS	Aquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwives
BSY	Balika Samridhi Yojna
CDWS	Center For Development Of Women Studies
CHC	Community Health Center
CPR	Contraceptive Prevalence Rate
CSD	Council For Social Development
CSW	Commission On the Status Of Women
CDI	Composite Development Index
DPEP	District Primary Education Programme
DWCRA	Development Of Women And Child In Rural Area
ECCE	Early Children Care Education
EAS	Employment Assurance Scheme
EMW	Ever Married Women
EPI	Expended Programme On Immunization
FIR	First Information Report
FR	Fertility Rate
GAD	Gender and Development
GER	Gross Enrolment Ratio
GPI	Gender Parity Index
GNP	Goss National Product
GDP	Gross Domestic Product
HRD	Human Resource Development
IAS	Indian Administrative Services
IAY	Indira Awaas Yojna
IDS	Institution of Development Studies
ILO	Indian Labour Organization

IPS	Indian Police Services
IMY	Indira Mahila Yojna
IRDP	Integrated Rural Development Programmae
ICDS	Integrated Child Development Child Services
IDC	Institute of Development and Communication
IEC	Information, Education and Communication
ICT	Information and Communication Technologies
IHDR	Indian Human Development Report
IPC	Indian Penal Code
IWCUA	Integrated Women's Empowerment Programme
IWEP	Integrated Women's Empowerment Programme
JGSY	Jawahar Gram Samridhi Yojna
KSY	Kishori Shakti Yojna
KVIC	Khadi Village Industries Corporation
LJP	Lok Jumbish Programme
LHVs	Lady Health Visitors
MDG	Millennium Development Goal
MCH	Maternal Child Health
MNC	Multi-National Corporation
MSP	Mahila Samakhya Programme
MTOT	Master Training Of Trainers
NCBR	National Crude Birth Rate
NCWI	National Council Of Women In India
NFHS	National Family Health Survey
NFE	Non-Formal Education
NGO	Non-Government Organization
NIRD	National Institute Of Rural Development
NLM	National Literacy Mission
NPE	National Policy On Education
NORAD	Training Cum Production Centers For Women
NTP	National Training Policy
ORT	Oral Rehydration Therapy

PDS	Public Distribution System
POA	Programme Of Action
PRI	Panchayati Raj Institutions
RMK	Rastriya Mahila Kosh
RCH	Reproductive Child Health
SCR	Sachar Committee Report
SDI	Social Development index
SEWA	Self Employed Women Association
SGSY	Swarnajayanti Gram Sarojgar Yojana
SHG:	Self Help Groups
SIRD	State Institute Of Rural Development
SJSRY	Swarnajayanti Shahari Rojgar Yojana
SKP	Shiksha Karmi Programme
SSA	Sarva Shiksha Abhiyan
STEP	Support to Training Cum Employment programme
SUD	State Urban Development Agency
TNCs	Trans National Corporations
UEE	Universaliztion of Elementary Education
UN	United Nation
UNDP	United Nation Development Programme
UNICEF	United Nation Children Fund
UNESCO	United Nation Education Scientific And Cultural Organization
WHO:	World Health Organization
WEP	Women Empowerment Programme
WID	Women In Development
WIA	Women's India Association

CHAPTER-1

HEALTH AND EMPOWERMENT

A study of the Physical, natural or social phenomenon would require concretizing a concept related to that phenomenon and evolving suitable methods to investigate the inter-relatedness of various components involved in it. Natural phenomena related to physical and biological aspects of human growth and development have been studied with great scientific precision, following the principles of physical or natural sciences. However, the understanding of a social phenomenon assumes greater complexity due to the interactions of physical, social, cultural, psychological, economic and environmental factors on the behavior patterns of individuals and groups.

Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture. Among definitions still used, probably the oldest is that health is the "absence of disease". In some cultures, health and harmony are considered equivalent, harmony being defined as "being at peace with the self, the community, god and cosmos".

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a world-wide social goal; that it is essential to the satisfaction of basic human needs and to an improved quality of life; and that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that the main social target of governments and WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", for brevity, called "Health for All" (Park, K., 2001).

Health is one such phenomenon which is hard to define. Due to inherent limitation of a well-defined concept, it is difficult to measure or determine it with exactness.

Concept of Health

The concept of health may be regarded a situated concept. One may be in health as 'now' and 'then' and the next moment, the same person may become unhealthy, sick and ill, which is obverse of health. This implies that health is to be viewed in a time framework and in the context of a socio-cultural or physical environment. This does not, however, mean that one cannot conceive health with a consistent pattern of its presence or absence (Mehta, S.R., 1992, p-12).

The survival of any human society is inextricably linked with the health of its population. Since ancient times, human beings and societies have tried to discover rules and protocols that would enhance chances of sustained good health. Health is a basic human right of people. U.N. Charter defines human rights as about respecting, protecting and fulfilling the inherent dignity of the individual as well as promoting the ability of each individual to reach his or her potential, in the context of equality self determination, peace and security. Good health is primary resource for development. Physical, emotional and mental well being leads to sufficient energy, physical strength and harmony in life allowing people to be productive and deal creatively with the development of society, the family and individuals (Yadavendu, 2003,p. 5180).

According to WHO (World Health Organization) (1948), "Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity". Health is multi-dimensional phenomenon consisting of physical, mental and social dimensions.

Physical health implies the notion of "perfect functioning "of the body which refers to the biological state in which every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. The signs of physical health in an

individual are: a good complexion, a clear skin, bright eyes, lustrous hair with a body well clothed with firm flesh, not foot fat a sweet breath, a good appetite, sound sleep, and smooth, easy, coordinated bodily movements.

Good mental health is the ability to respond to the various experiences of life in a sensible manner with flexibility. In broader sense, mental health can be defined as a state of balance and harmony between oneself, other people and that of the environment.

The social dimension of health includes social functioning and ability to see oneself as a member of larger society. In general, social health takes into account that every individual is family member of society (wider community) and focuses on social and economic environment of "whole person" in the context of his social network. Social health is rooted in "positive material environment" (focusing on financial residential matters), and "positive human environment" which is concerned with the social network of the individual (Park, K. 2005, pp.13-14)

Determinants of Health

The factors which influence health lie both within the individual and external to him, in the society in which he or she lives. It is true to say that what man is and what diseases he may fall victim depends on a combination of two sets of factors- his genetic factors and the environmental factors to which he is exposed. There are many determinants of health which are as follows:

1. Biological determinants
2. Behavioural and socio-cultural conditions
3. Environment
4. Socio-economic conditions
5. Health services
6. Aging of the population
7. Gender
8. Other Factors

Biological Determinants

The physical and mental traits of every human being are to some extent determined by the nature of his genes at the time of conception. From the genetic point of view, health may be defined as that "state of the individual which is based upon the absence from the genetic constitution of such genes which correspond to characters that take the form of serious defect and de-arrangement and to the absence of any aberration in respect of the total amount of chromosome material in the karyotype or stated in positive terms, from the presence in the genetic constitution of the genes that correspond to the normal characterization and to the presence of a normal karyotype" (Crew,1965).

Behavioural and Socio-Cultural Conditions

Health requires the promotion of healthy life style. The term "lifestyle "is rather a diffused concept often used to denote "the way people live", reflecting a whole range of social values, attitudes and activities. It is composed of cultural and behavioural patterns and lifelong personal habits (e.g., smoking, alcoholism) that have developed through processes of socialization. Lifestyles are learnt through social interaction with parents, peer groups friends and siblings and through school and mass media.

Environment

Environment has strong effect on the health of individual in a society. Environment is classified as "internal" and "external". The internal environment of man pertains to each and every components part, every tissue, organ and organ-system and their harmonious functioning within the system". The external or macro environment consists of those things to which man is exposed after conception. It is defined as "all that which is external to the individual human host" (Last, J.M. 1983).

Socio-Economic Conditions

Socio-economic condition influences human health to a great extent. For the majority of the world's people, health status is determined primarily by their level of socio-economic development, e.g., per capita GNP, education, nutritional employment, housing, the political system of the country, etc.Some of the constituents are:

i Economic Status: The economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behavior in the community. It is also an important factor in seeking health care.

Ii Education: A second major factor influencing health status is education (especially female education). Studies indicate that education, to some extent, compensates the effects of poverty on health, irrespective of the availability of health facilities. The small state of Kerala in India is a striking example. Kerala has an estimated infant mortality rate of 14 compared to 71 for all-India in 1999. A major factor in the low infant mortality of Kerala is its highest female literacy rate of 87.86% compared to 54.16% of all-India.

Iii Occupation: The very state of being employed in productive work promotes health, because the unemployed usually show a higher incidence of ill health and death.

Iv Political system: Health is also related to the country's political system. Often the main obstacles in the implementation of health technologies are not technical, but rather political. Decisions concerning resources allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services.

Health Services

The term health and family welfare services cover a wide spectrum of personal and community services for treatment of decease, prevention of illness and promotion of health. The purpose of health is to improve health status of

population. For example, immunization of children can influence the incidence/prevalence of particular diseases. The care of pregnant women and children would contribute to the reduction of maternal and child morbidity and mortality. To be effective, the health services must reach the social periphery, equitably distributed, accessible at a cost the country and community can afford and socially acceptable.

Aging of the Population

By the year 2020, the world will have more than one billion people aged 60 and over and more than two- third of them living in developing countries. Although the elderly in many counties enjoy better health than hitherto, a major concern of rapid population aging is the increased prevalence of chronic diseases and disabilities both being conditions that tend to accompany the aging process and deserve special attention.

Gender

In 1993 the Global Commission on Women's Health was established. The commission drew up an agenda for action on women's health covering nutrition, reproductive health, the health consequences of violence, aging, lifestyle related conditions and the occupational environment. It has brought about an increased awareness among policy-makers of women's health issues and encourages their inclusion in all development plans as a priority.

Other Factors

Other contributions to the health of population derive from systems outside the formal health care system, i.e., health related system (e.g., food and agriculture, education, industry, social welfare, rural development) as well as adoption of policies in the economic and social fields that would include employment opportunities, increased wages, prepaid medical programmes and family support system (Park, K., 2005, pp 17-19).

INDICATORS OF HEALTH

Health Indicators play significant role not only in measuring the health status of community, but also in comparing the health status of one country with another. It is also used for assessment of health care needs; for allocation of scarce resources; and for monitoring and evaluating of health services, activities and programmes. Indicators help to measure the extent to which the objectives and targets of a programme are being attained. Health is a multidimensional phenomenon, and each dimension is influenced by numerous factors. There are many indicators which may be classified as:

1. Mortality Indicator
2. Morbidity Indicator
3. Disability rates
4. Nutritional status indicators
5. Health care delivery indicators
6. Utilization rates
7. Indicators of social and mental health
8. Environmental Indicators
9. Socio-economic Indicators
10. Health policy Indicators
11. Indicators of quality of life
12. Other Indicators

1- Mortality Indicators

The following indicators are generally used to asses mortality:

a. Crude death rate
b. Expectation of life
c. Infant mortality rate
d. Child mortality rate
e. Under-5 proportionate mortality rate

2- Morbidity Indicators

It is used to supplement mortality data to describe the health status of a population. Describe health in term of mortality rates only is misleading. This is because,

mortality indicators do not reveal the burden of ill health in a community, for example mental

illness and rheumatoid arthritis. Morbidity statistics have also their own drawback; they tend to overlook a large number of conditions which are sub-clinical or in apparent, that is, the hidden part of the iceberg of disease.

The following morbidity rates are used for assessing ill health in the community.

a. Incidence and prevalence
b. Notification rates
c. Attendance rates at out-patient departments, health centers, etc.
d. Admission, re-admission and discharge rates
e. Duration of stay in hospital and
f. Spells of sickness or absence from work or school

3. Disability Rate

Since death rates have not changed markedly in recent years, despite massive Health expenditures, disability rates related to illness and injury have come into use to supplement mortality and morbidity indicators. The disability rates are based on the premise or notion that health implies a full range of daily activities. The commonly used disability rates fall in two groups: (a) Event-type indicators and (b) Person-type indicator.

4. Nutritional Status Indicators

Nutritional status is a positive health indicator. Three nutritional status indicators are considered important as indicator of health status. They are:

a. Anthropometric measurement of preschool children, e.g., weight and height, mid arm circumstances;
b. Heights (and sometimes weight) of children at school entry; and
c. Prevalence of low birth weight (less than 2.5 kg).

5. Health Care Delivery Indicators

The frequently used indicators of health care delivery are:

a. Doctor-population ratio
b. Doctor-nurse ratio
c. Population-bed ratio
d. Population per health/sub-centre
e. Population per traditional birth attendant.

6. Utilization Rates

Utilization services are expressed as the proportion of people in need of a service who actually receive it in a given period, usually a year. Health care utilization is also affected by factors such as availability and accessibility of health and the attitudes of an individual towards his health care system. A few examples of utilization rates are cited as follows:

a. Proportion of infants who are "fully immunized" against the 6 EPI diseases.
b. Proportion of pregnant women who receive antenatal care, or have their deliveries supervised by trained birth attendant.
c. Percentage of the population using the various methods of family planning.
d. Bed-occupancy rate (i.e., average daily in-patient census/ average number of beds).

7. Indicators of Social and Mental Health

As long as valid positive indicators of social and mental health are scarce, it is necessary to use indirect measurers, viz. indicators of social and mental pathology. These include suicide, homicide, other acts of violence and other crime, road traffic

accident, juvenile delinquency; alcohol drug abuse, smoking, conception of tranquilizer etc..

8. Environmental Indicator

Environmental indicators reflect the quality of physical and biological environment in which diseases occur and in which the people live. They include indicators relating to pollution of air and water, radiation, solid wastage, noise, exposure toxic substances in food or drink.

9. Socio-Economic Indicators

These indicators do not directly measure health. Nevertheless, they are of great importance in the interpretation of the indicators of health care. These include:

a. Rate of population increase
b. Per capita GNP
c. Level of unemployment
d. Dependency ratio,
e. literacy rates, especially female literacy rates
f. Family size
g. Housing: the number of persons per room
h. Per capita "calorie" availability

10. Health Policy Indicator

The single most important indicator of political commitment is "allocation of adequate resources". The relevant indicators are: (i) proportion of GNP spent on health services (ii) proportion of GNP on health-related activities (including water supply and sanitation, housing and nutrition, community development) and (iii) proportion of total health resources devoted to primary health care.

11. Indicator of Quality of Life

Increasingly, mortality and morbidity data have been questioned as to whether they fully reflect the health status of population. The previous emphasis on using increased life expectancy as an indicator of health is no longer considered adequate, especially in developed countries, and attention has shifting more toward concern about the quality of life enjoyed by individual and communities.

12. Other Indicators Series

Social indicators- Social indicators, as defined by the United Nations Statistical Office, have been divided into 12 categories: population; family formation, families and households; learning and educational services are some of these (Park,K. 2005, pp. 22-25).

Concept of Empowerment

Empowerment is a concept that has become popular in recent times to describe an enabling process for socially marginalized persons and groups to gain advantage and opportunities otherwise non-available to them. Serageldian describes it as "The empowerment idea manifests itself at all levels of societal interaction. It is found in giving a voice to the disenfranchised, in allowing the weak and the marginalized to have access to the tools and the materials they need to forge their own destinies" (Serageldian, 1991, pp.88-90)

Empowerment is a process which helps people to gain control over their lives through raising awareness, taking action and working in order to exercise greater control. In other words, empowerment facilitates change and enables a person to do what one wants to do. Empowerment is the feeling that activates the psychological energy to accomplish one's goals. From the institutional perspective, empowerment is the process of setting the right environment and structure and creating the circumstances where people can use their faculties and abilities to fully actualize their potential. Women should get access to those modes and mediums of

expression of their self-actualization and through that they can achieve empowerment (Sinha, 2006, pp. 6).

Women's empowerment means that women no matter where they are, are healthy, have enough for their needs, their own survival and that of their family and community, to be able to live with dignity, live and work in safe and caring environment, which allows their growth and holistic development, i.e., physically, emotionally, socially, economically. Women's empowerment means that they can take decisions about their life, their children and family and also contribute to the community decisions, where women's right to 'personhood', 'bodily integrity' is respected, where their reproductive rights, social economic and political rights are respected, i.e., their work and contribution to the family, society is recognized, where there is no fear of sexual and social violence, where women feel a sense of acceptance and belonging, where their right to their home and to children as guardians is respected.

Women's empowerment means that women are able to have control over their resources, where they are given opportunities to learn, to develop skills, to travel, to contribute, to benefit from the results and outcome of their work, where their unpaid housework is valued and appreciated and the burden shared in true spirit of partnership.

The year 2001 was the year of Women's Empowerment. The last decade saw ICPD, Cairo, Beijing Conference, Social Summit, Copenhagen, Human Rights, Vienna. There is no denying that in some areas women have been given opportunities, which they have well utilized, e.g., in terms of education and work opportunities. Yet the fact remains that as women are shouldering home, fulfilling their reproductive roles as well as responsibilities outside, besides caring for in-laws, children, animals, etc., the changes in male behavior, in terms of helping in child care, house work, has not happened. Even women have also become 'bread winners' as well as 'Roti makers', their burden has undoubtedly only increased with little or no help from the spouses(Sharma, Priyanka,2008, pp 48-50).

Empowerment is the term that refers and contains within it the word "Power". It is something that can be given to a person that he/she does not have. The Oxford Dictionary while dealing with this term define it as a giving 'official authority' or 'legal power to', it further elaborates that the prefix "em" originates from a Latin root and implies that the object 'power' being placed upon another. It implies that power is a commodity to be bestowed on a previously "underpowered group".

It is also being defined as a process that connotes the existing power relations and of gaining greater control over the source of power. It further requires political action and collective assault or cultural as well as national and community power structures that oppress women and some men.

Empowerment is a process of awareness and capacity building leading to greater participation, to greater decision-making power and control, and to transformative action.(Sahay, Sushma,1998, pp-22)

Moser defines economic empowerment as crucial for addressing issues of gender inequality; it is not seen as a sufficient condition in itself. She agrees that self esteem and a sense of self confidence also plays an important role in the women's potential to mobilize external strength for bringing about fundamental change (Moser, 1989, pp.17).

According to Kabeer 'empowerment is the process by which those who have been denied the ability to make strategic choices acquire such ability'. She argues that 'for women to improve their ability to control resources, to determine agendas and make decisions, empowerment strategies must built on the 'power within' as a necessary adjunct. Kabeer is also emphasizing the importance of self respect and sense of agency in the empowerment process. Even though Kabeer views the process as involving transformation at a personal level, she suggested that collective action is important for social and political empowerment (Kabeer, 1990).

Batliwala emphasizes that empowerment strategies should build on collective processes, which are crucial for personal empowerment. She describes empowerment as "the exercise of informed choice within an expanding frame work of information, knowledge analysis and process which enable women to discover new possibilities and new option" (Batliwala, 1995, p. 60).

Dimensions of Empowerment

As far as Women's empowerment is concerned, it is about gaining autonomy and control over one's life which includes many dimensions: Political, Social, Psychological, Cultural, Economic and Ecological dimensions. Meenakshi Malhotra has defined the four types of dimensions: individuals or personal, economic, collective/social group and political. Empowerment of women is multi-dimensional concept. The following sections focus upon necessary dimensions for attention to facilitate meaningful women empowerment which are ultimately considered to be the key factors in social development (Malhotra, Meenakshi, 2004, pp. 58-59).

1. Economic Empowerment

Economic empowerment is the individual aspect of women development. The economic empowerment means greater access to financial resource inside and outside the household, reducing vulnerability of poor women to crisis situation like famine, flood, riots, death and accidents in the family and significant increase in income of women.

Economic empowerment gives women the power to retain income and use it at her discretion. Financial self-reliance of women both in the household and in external environment leads to the empowerment of women in the other sphere (Pandian & Eswaren, 2002, pp.47-50).

Economic empowerment organized women into self help groups under various poverty alleviation programs, viz. Swarnajayanti Gram Swarojgar Yojana (SGSY), Swarnajayanti Shahari Rozgar Yojana(SJSRY), Rastriya Mahila Kosh (RMK), Support for Training And Employment Programme (STEP), training cum production centers

for women (NORAD), etc. and offering them arrange of economic option along with necessary support measures to enhance their capability and with an ultimate objective of making them economically independent and self-reliant. Economic empowerment has three aspects attaining the income security, ownership of productive asset and entrepreneurship skills. Information technology also work for women empowerment which cuts across various fields such as helping women improving agriculture productivity in their farms, encouraging them to become entrepreneurs and information intermediaries.

Female roles are seen as reproductive and domestic and in support of the male breadwinners of the family and this practice has conditioned women to accept a subservient role. The fact that women though largely absent from the formal workplace and hence from official labour statistics are nevertheless heavily engaged in subsistence agricultural and informal sector of economy. There is constant effort to put women's income in bracket in order to consolidate the position that women are only reproducers and not producers. This idea need to be engaged. Women's economic right is definitely an important indicator for enhancement of their status. So, women's labour needs to be recognized. Education, more employment avenues, political awareness etc., would all lead to women's economic emancipation.

2. Social Empowerment

Social empowerment means equal status, participation and power of decision making at the house hold level and at the community and village level. Social empowerment of women enables them to participate in decision –making process in democratic institutions. It creates an enabling environment through various affirmative development policies and program for development of women besides providing them easy and equal access to all the basic minimum services so as to enable them to realize their full potentials.

Advancement of women is the institutionalized set of social prescription that limits their participation in socio-economic activities and their input in decision

making. Odejide(1990), recognizes that the emergence of female entrepreneur's process depends upon closely linked economic, social, religious and psychological variables. While empowering women requires fundamental changes at many levels of society, arguably the most complex and elusive transformation may be in the relations within the household and family.

3. Physical Empowerment

Most women of third world countries work very long hours at numerous tedious tasks as well as take care of their children and homes. Given their low social status, there is usually more concern with their productivity and the number of children they raise than with their physical well being. Physical empowerment is indivisible from other aspect of empowerment.

Until we recognize the physical hardship ensured by women from meeting their productive and reproductive responsibilities and make concerted efforts to improve their health status, other advancement will have limited impact for them. Physical empowerment is dependent upon each of other dimensions as all have contributory effects.

4. Psychological Empowerment

Psychological empowerment is another dimension which gives power to women and girls. In Indian cultural ideology that female hereto right from the young age, calls for self eradicate and looks upon suffering as on 'exaltation' of feminine goodness. Girls are indoctrinated in the conviction that they are, as female, 'worthless' and not entitled to claim anything, even as individuals. This imposition too has been significantly broken so that girl and women learn to think themselves as citizen with legitimate entitlements. Whether it is the right to vote according to her own choice and inclination or the choice for study, women have autonomy to a far greater extent than what their earlier generation had.

Empowerment gives women a reproductive right to choose how many children she can have. Previously women use to have seven, eight or more children without their choice or by voluntary decisions. Now, women have choices for contraception available and even in a position to exercise their choice to restrict their families. This significant psychological autonomy is the feature of the change brought in past one generation of women. In fact, compared to women in some of the economically advanced countries Indian women are able to access medical termination of unwanted pregnancies with far greater ease.

Udegbe recognizes that empowerment must also be seen as a 'psychological process of transformation' and that there is a need to 'reserve the feeling of learned helplessness' among women, leading to an 'increase in knowledge, capacity, self confidence, high self-esteem, self reliance and ultimately, to the well being of the empowered'.(Udegbe, 1996).

To accomplish this goal, Akande and Kuye state that women must understand the structural sources of their powerlessness and feel the need for the change- ready to be actively participating in the changes, both as individual and groups. Education can be powerful force to change the subordinate view that women have of themselves (Akande and Kuye, 1986, pp.335-41).

5. Political Empowerment

Political power has become the cornerstone of development planning and many matters pertaining to human rights of women are integrally linked to political empowerment. Equal participation of women in the political spheres plays a pivotal role in the process of their advancement and enjoyment of human rights. It is a necessary condition that is instrumental in increasing their ability to demand and secure their rights and entitlements. Their active role in political decision- making processes is necessary for redefining the political agenda and gender justice that may address the women's rights, and entitlements.

With the passing of the 73rd amendment to the constitution and because of one third reservations of seats for women at the local government level, more than one million rural women have, came into panchayat posts, as sarpanch or adhyaksha or members of community administration. This kind of political empowerment is described as unprecedented event in the developed countries of the west. Many of the panchayat women are illiterate and poor and came from backward communities, and yet, many of then have proved their mettle and won acclaim as able administrators.

Political participation is invariably an integral component of political empowerment. Historically women have played a very significant role in the growth and development of parliamentary democracy in India. They have held important positions both in the legislature and government. The contribution of females in the development of parliamentary procedures and practices is in no sense less significant than those of their male counterparts. Even outside the legislature, they have been socially and politically active (Narwani,2002).

Relationship between Health and Empowerment

Health starts from the birth and continues till death. India has made considerable progress in social and economic development in recent decades, as improvement in indicators such as life expectancy, infant mortality, and literacy demonstrate. However, improvements in women's health, particularly in the North, have lagged behind gains in other areas. The condition of women's health is poorer than men. The socially constructed differences between women and men lead to the discrimination against women even before the birth. Women are often seen as having lower status. Yet, women bear the entire burden of childbearing and child rearing.

Low marriage age has number of other adverse implications: it is usually associated with high early fertility, which affects women's nutrition and health status; it tends to reduce women's autonomy and agency in the marital home and to

create conditions of patriarchal subservience that get perpetuated through life, and it thereby often reduces self-worth.

This in turn may affect women's work participation in direct and indirect ways. It is well known that the work participation of Muslim women is very low, but the studies indicates that this may less due to the force of religion per se than to the patriarchal structures and patters as well as low mobility and lack of opportunity that define their lives. It is worth noting that the work participation rate of women across communities tends to be low in certain regions, in the north and east especially.

Some of this is due to straightforward control over women's agency by male members of the household. Seventy five percent of the women in a survey conductedby Jayati Ghosh (both Hindu and Muslim) reported that they need permission from their husbands to work outside the home. Interestingly, the study revealed that less autonomy of decision-making within the household. Less than 10 per cent of the respondents took any decisions on their own in major or minor matters, and among the 30 per cent who took decisions jointly with their husbands, Muslim women reported greater consultation than Hindus for all categories of decisions. Clearly, however, patriarchal control remains one important constraint upon the outside work of women, among Muslims as well as certain other social categories (Ghosh, Jayati, 2004, pp. 3-4).

Women's health needs are generally accorded low-priority, as is well-known from innumerable studies on their health status, but what is notable in our data is the community difference. Muslim respondents report a significantly higher need for obtaining permission for this than Hindus. It is possible that primary health-care centre are less readily accessible to Muslim women who may have to travel a longer distance, or that they are generally manned by male doctors; or that only private medical care is readily available and so permission is required to pay for it. For an economically depressed community, this would be an important consideration (Hasan, zoya and Menon, Ritu, 2004, p.159).

Muslim Women, like other women, have been suffering for long for lack of empowerment in a male-dominated society. Pakistan and Bangladesh, once part of India, have been no different in this respect. The women there suffered as much as in India for lack of rights. However, some changes were, enacted in the Muslim personal law in Pakistan in 1961 during Ayub Khan's regime under intense pressure from women's organisations.

There is strong evidence that gender systems persist in playing a strong role in explaining reproductive and contraceptive behaviors and choice, even after controlling for women's autonomy. For the most part this influence surpasses either nationality or religion. Women from Tamil Nadu, irrespective of religion, are significantly more likely than those from Uttar Pradesh or Punjab to practice contraception, and have met their need for family planning, even after a host of socio-demographic and autonomy indicators are controlled. Patterns experienced by women in the two northern sites of South Asia resemble each other, despite national and religious differences. The results of the multivariate analysis do suggest that religion and nationality have a significant influence on predicting reproductive behavior (both intentions and action upon those intentions), however these influences are considerably weaker than that exerted by region. They also suggest that being a Muslim or a Hindu has quite different ramifications for reproductive behavior depending on the region of residence.

Health care access remains low for many women, especially the poor and marginalized who suffer from multiple exclusions and stigmatized groups such as sex workers and women with alternative sexualities. The Eleventh Plan recognizes the gender dimension of health problems and seeks to address issues of women's survival and health through a life cycle approach. Making ordinary women partners in their own health care is an underpinning of Women's Health in the Eleventh Plan.

The Eleventh Plan agenda is to move beyond the traditional focus on family planning and reproductive health, to adopt a holistic perspective on women's health. For this, allocation towards health is being stepped up.

The high rates of MMR and IMR, poor prenatal and postnatal care, combined with the low proportion of institutional deliveries, are a grave cause of concern. Empowering adolescent girls through information about health, sexuality, and increased awareness to negotiate rights with families, future partners, and in the workplace is equally important. The challenge is to create an enabling environment with information, services, and health programmes for women to exercise their rights and choices

Many other factors affect the health of women. For instance women's risk of mortality from indoor air pollution resulting from use of unprocessed fuels is estimated to be 50% higher than of men. While over time, community investment in low cost clean fuel such as biogas will be encouraged, in the interim, firewood needs to be made available. Provision of clean drinking water and sanitation facilities are also important for good health. Inter-sectoral convergence to ensure the health and well being of women in this regard is a major challenge before the Eleventh Plan.

Minority women are typically engaged in home-based, subcontracted work with lowest levels of earnings. The Sachar Committee Report has pointed out the absence of adequate social and physical infrastructure and civic amenities in Muslim-dominated habitations and the multiple discriminations faced by Muslim women. To fulfill its agenda for inclusive growth, the Eleventh Plan will ensure that Muslim localities are provided with universal benefits of primary and elementary schools, water, sanitation, electricity, public health facilities (PHCs), anganwadis, ration shops, roads, transport facilities, access to government development schemes and facilities, such as BPL cards and widow pensions. Education will be made accessible for Muslim girls by locating educational institutions near Muslim areas, establishing some girls' schools, and increasing scholarships for Muslim girls. The challenge is to make technical and higher education opportunities available to minority women and to link them to employment. Access to low interest credit, markets, technical training, leadership training, and skill development for Muslim female home-based workers and entrepreneurs will be ensured. Representation of religious minorities in

public employment will be increased and minority women will be provided access to institutional and policy level decision-making.

In view of the double discrimination faced by Muslim women, the Prime Minister's 15-point programme for the minorities is a critical statement of intent. To further this agenda of inclusive growth, MoWCD will work on a pilot scheme for 'Minority Women' to empower them and place them in the forefront of making the government system at the grassroots responsive to the needs of the minority community. Such a scheme will provide critical learning and benchmarks to launch more ambitious programmes for minority women in subsequent plans. In addition to this, targeted development of SC, ST, and minority women will be made a stated part of implementation strategies of all WCD programmes/schemes and of the SSA. It will be made a mandatory part of their parameters of review and monitoring guidelines.

Women's autonomy index shows a stronger effect on women's likelihood of being in need of contraception as well as on women's likelihood of using a modern-temporal method than decision making power does. A quite heavy effect on women's likelihood of using contraception is related to husband's agreement with contraception, except for women with high decision-making power and high autonomy. Women's likelihood of using a definitive method (sterilization) does not show a significant relationship with any of the women's empowerment indicators included. Finally, the proportion of women in need of contraception but not using any contraceptive methods, related to husband's will against fertility control and women's lack of knowledge regarding contraceptive methods, show a significantly reduced prevalence among more empowered women..

India is considered an overpopulated country and India's population policy seeks to achieve replacement low fertility by 2010. However, population policy implementation in India has come severe attack, more so due to the element of coercion inherent in the promotion and acceptance of modern contraceptives. Besides, Indian population policy does not adequately recognize the multi-dimensionality of the economic and social forces that prevail upon the household decisions regarding the size of families. The population programme is over

dependent on female sterilization with little or no choice based access to a basket of family limitation procedures. There is little recognition of the fact that ultimately it is development and equity that empowers citizens to make informed choices with respect to family formation. In this regard the impact of education, especially of women, has shown dominant influence, not only in reducing fertility but also in the reduction of infant and child mortality, improvement in birth weights and overall human development (Sachar Committee, p-27).

Most populations in the world have more women than men. At birth share of boys is always higher, around 105 boys per 100 girls, but higher mortality among males compared to female's leads to a sex composition favourable to females. However, India and some South Asian countries differ from this pattern. Female mortality was higher than male mortality in these parts though now this is not the case and the mortality gap is quite narrow. As a result, there are more men than women in India and the sex ratio (females per thousand males) is lower than 1000; for the period 1961-2001 this hovered around 930 (Sachar Committee, p-33).

It is useful to note here that infant and under-five mortality rates are commonly used as good indicators of mortality. Reduction in infant and child mortality is one of the highest public health priorities in India and one of the most important millennium development goals, as children are the most important assets of a nation. India has high levels of infant and under-five mortality in comparison to other countries at its level of per capita income and in comparison to neighbouring countries such as Sri Lanka and Bangladesh.

Estimates from different surveys as well as indirect census-based estimates show that infant and childhood mortality among Muslims is slightly lower than the average. As is well-known, infant and under-five mortality Is influenced by biological and socioeconomic variables, such as a child's sex and birth order, the mother's schooling and household economic status.

The total fertility rate (TFR) is the most widely used summary indicator of fertility; this is the number of live births a woman has on an average during her

lifetime, if she goes through the reproductive span, following a given age-specific fertility schedule. These show that among the four large religious groups fertility is the lowest among the Sikhs, closely followed by the Christians and the highest among the Muslims. The TFR for Muslims is higher than the average by 0.7 to one point as seen from the NFHS-1, NFHS-2, and Census estimates. Other measures of fertility also show higher values for Muslims. For instance, the crude birth rate (CBR), estimated from Census figures is also higher among Muslims (30.8, against 25.9 for the total population and 24.9 for Hindus). There has been a large decline in fertility in all the religious groups; whereas in the pre-transition period the TFR was above 6, in recent years it has fallen below 4. Thus, the process of fertility transition is in progress in all communities. The recent level observed for Muslims (from either the NFHS-2 estimate or the 2001 Census estimate) cannot be described as 'high fertility', but can be referred to as 'moderate fertility'. It must be clarified here that while discussing the fertility of a community, we are really talking of the average rather than a common characteristic. Fertility varies among Muslims according to socio-economic characteristics as well as on the level of the individual and there are large regional variations in fertility in India. While some states have reached a very low level fertility, with TFR close to 2.1, or near the replacement level, the north-central states have moderate levels of TFR, closer to 4. In states that have low fertility, the fertility of Muslims is also low, though higher than average. In fact, Muslims in the southern states have lower fertility than the average in the north-central states.

The relatively high fertility of a section of the population could be on account of various factors. A low age at marriage obviously is conducive to high fertility. However, recent data show that Muslims do not have a lower age at marriage than average. A point made on the higher fertility of Muslims was that the proportion of women married in reproductive ages was relatively high, because widow remarriage is well accepted in the Muslim community unlike the Hindus. However, recent data from the 2001 census show that the marital status distribution of Muslim women is not notably different from that of the general population in the reproductive age groups, the ages that matter for fertility. The other important factor contributing to fertility differential is the use of contraceptives. The use of contraception is widely

prevalent among Muslims but to a lesser degree than the average. In contraceptive prevalence rate, there is a gap of about 10 percentage points between Muslims and the average. A careful examination reveals that it is the use of sterilization that shows a wide gap. Apparently, reversible methods are used relatively more commonly by Muslims compared to others. But sterilization is less popular among Muslims. 'Unmet need' for contraception is relatively high amongst Muslims, and there is evidence of a large demand for reversible methods.

The facts do not support the common perception that Muslims shun family planning, as over one third of Muslim couples were reported to be using some contraception (in any case, use of contraception cannot be very high, say over 70%, for any large population group since those with no children or with just one child normally want an additional child and those with primary sterility do not need contraception) (Sachar Committee, pp-36-40).

While the speculation on population share generates much debate, this is not likely to influence fertility decisions to a major extent. Couples take decisions on fertility in their own interests rather than for raising community's share in the population or for gaining political power for the community. This seems to be true of all communities, majority or minority. Individual considerations of child bearing, costs of children and perceived values, are more important than community exhortations. As recent evidence suggests, there is general acceptance of the idea of fertility regulation, a small family is desirable, and contraceptive services are sought and utilized. The last three decades show that fertility has declined substantially in India and contraceptive practice has become common. Further, the population growth rate has declined in the last decade and recent estimates show that the decline is continuing. Moreover, this has happened for all the major communities including the Muslims. The growth rate for Muslims, as for the total population, is bound to fall further and eventually reach a zero growth stage. There are strong indications that this could occur well before the end of the century (Sachar Committee, p-46)

The analysis of demographic and a health condition in a comparative perspective bring out often interesting insights:

- Muslim population growth has slowed down, as fertility has declined substantially clearly showing that Muslims are well into demographic transition. In the future, growth is bound to be slower and eventually population is bound to reach replacement level.

- The demographic transition is lagging in the north-central region for Muslims as well as for others and a speedier change in this region will mean a speedier transition for Muslims.

- Contrary to common perception, there is substantial demand for fertility regulation and for modern contraception among Muslims. This calls for the programme to provide better choices to couples.

- In mortality and child health, Muslims fare marginally better than average but as the overall health conditions are unsatisfactory, efforts are needed to improve them. Addressing health needs of the urban poor would alleviate conditions of poor Muslims as many live in urban areas in the southern and western states.

- The spatial distribution of Muslim population is uneven with high concentration in some states that are lagging behind in development. Bringing down regional disparities could go a long way in reducing demographic disparities (Sachar Committee, p-47).

REFERENCES

1. Akande, Jade O. and Priscilla O. Kuye. (1986), "Nigeri: Family Law Project", In Margaret Schuler (ed.), Empowerment and the Law: Strategies of Third World Women, Washington D.C.: OEF International, pp.335-41

2. Crew. (1965). Health its Nature and Conservation, Pergamon press, London.

3. Ghosh, Jayati. (2004)."Muslim Women in India", Frontline, Vol. 21, Issue-19, publisher, The Hindu.

4. Hasan, Zoya & Menon, Ritu. (2005), Unequal Citizen, Oxford University Press, New Delhi, p. 159

5. Kabeer, N. (1990), 'Gender Development and Training: Rising Awareness In Development Planning", GAADU Newspack No. 14.

6. Last J. M. (1983). A Dictionary of Epidemiology, Oxford University Press.

7. Malhotra, Meenaksh. (ed.), (2004), Empowerment of Women, Delhi, Isha Books, pp. 58-59

8. Mehta S. R., (1992), Society and Health, Vikas Publishing House, pp. 11-12

9. Moser, M. (1989), "Gender planning in the Third World: Meeting Practical and Strategic Gender Needs", World Development, pp. 17.

10. Narwani, G.S. (2002). "Training for Rural Development", Rawat publication, New Delhi

11. Odejide, A. F. (1990), "Appropriate Strategies for Improving Women's Participation in the Rural Industrialization Process", paper presented at the national workshop on women in development sponsored by the National Center for Economic Management and Administration (NCEMA0 held at the Premier Hotel, Ibadan on 28 January-2 February

12. Pandian, Punithavathy and Eswaran, R. (2002), Empowerment of women through Micro-credit, Yojana, Vol. 46, pp. 47-50]

13. Park. K. (2005). Preventive and Social Medicine, published by M/s Banarsidas Bhanot, Prem Nagar, Jabalpur, 482001 (India), pp. 13-14

14. Sachar Committee Report

15. Sahay, Sushma.(1998), Women and Empowerment (Approaches And Strategies), Discovery publishing house, New Delhi.

16. Serageldian, Ismail. (1991), "culture: Empowerment and the Development Paradigm" Development I

17. Sharma, Priyanka.(2008), "Womens empowerment and working women", Book Enclave, Jaipur.

18. Sinha, Debotosh. (2006), "Empowering Women: A Catalyst in Social Development" in Reddy, kumar and Nalini (ed.) Women in Development: Challenges & Achievments, Serials publication,Delhi, p-6.

19. Udgebe, I. Bola. (1996), "Empowerment: A Historical and Conceptual Analysis", in L. Erionsho, B. Ostimehin and J.E. Olawoye (ed.), Women's Empowerment and Reproductive Health, Ibadan, Social Science and Reproductive Health Research Network.

20. Yadavendu, Vijay, Kumar. (2003), "Changing Perspectives in Public Health: From Population to an individual", , Economic and Political Weekly, Vol. XXXVII, No.49, pp. 5180

21. (www.kumj.com.np/past/Vol1/issue4/294.pdf).

22. (www.un.org/esa/.../complelingfertility/RevisedCosio-Zavalapaper.PDF)

23. (http://www.cpdsindia.org/southasianhumansecuritywatch3ed.htm).

24. http://www.macroscan.com/the/employment/sep04/emp170904Muslim_Women.htm

CHAPTER -2

MUSLIMS IN INDIA
(A GENERAL PROFILE WITH REFERENCE TO WOMEN)

India is a multi-cultural, multi-ethnic and multi-lingual country. People belonging to many religions such as Hinduism, Buddhism, Jainism, Sikhism, Islam and Christianity live in this country since time immemorial. However, there appear to be substantial differential in the socio-economic and demographic profiles of major religious communities in India, mainly emerging from socio-cultural and historical reasons (Shariff, Abusaleh, 1995, pp-2947-2953).

Islam is India's second-most dominant religion after Hinduism, with more than 13.4% of the country's population and over 154 million people identifying themselves as Muslims. India is a home to the world's third-largest Muslim population after Indonesia and Pakistan, and the largest Muslim-minority population in the world.

Table 2.1 reveals that the largest concentrations-about 47% of all Muslims in India, according to the 2001 census—live in the 3 states of Uttar Pradesh (30.7 million,18.5%), West Bengal (20.2million, 25%), and Bihar (13.7 million,16.5%). Muslims represent a majority of the local population only in Jammu and Kashmir (67% in 2001). High concentrations of Muslims are found in the eastern states of Assam (31%) and West Bengal (25%), and in the southern state of Kerala (24.7%).

The analysis on religious data, among six major religious communities, shows that the decadal growth of the Muslims was the highest (36%) in the 2001 census. This statistic suggested that while growth rate for Hindus has fallen between 1991 and 2001 compared with 1981 and 1991, Muslims have actually grown faster in the last decade, this led Indian media and different parties raising an alarm at the growing number of Muslims and expressing concern about the demographic

imbalance and overpopulation, which the Indian government is desperately trying to stop democratically.

TABLE 2.1

Muslim population in Indian states according to 2001 census

State	Total Muslim Population	Percentage of Muslim Population in the state
Jammu & Kashmir	6,793,240	66.97
Assam	8,240,611	30.92
West Bengal	20,240,543	25.22
Kerala	7,863,842	24.70
Uttar Pradesh	30,740,158	18.50
Bihar	13,722,048	16.53
Jharkhand	3,731,308	13.85
Karnataka	6,463,127	12.23
Uttaranchal	1,012,141	11.92
Delhi	1,623,520	11.72
Maharashtra	10,270,485	10.60
Andhra Pradesh	6,986,856	9.17
Gujarat	4,592,854	9.06
Manipur	190,939	8.81
Rajasthan	4,788,227	8.47
Andaman & Nicobar Islands	29,265	8.22
Tripura	254,442	7.95
Daman & Diu	12,281	7.76
Goa	92,210	6.84
Madhya Pradesh	3,841,449	6.37
Pondicherry	59,358	6.09
Haryana	1,222,916	5.78
Tamil Nadu	3,470,647	5.56
Meghalaya	99,169	4.28
Chandigarh	35,548	3.95
Dadra & Nagar Haveli	6,524	2.96
Orissa	761,985	2.91
Chhattisgarh	409,615	1.97
Himachal Pradesh	119,512	1.97
Arunachal Pradesh	20,675	1.88
Nagaland	35,005	1.76
Punjab	80,045	1.57
Sikkim	7,693	1.42
Mizoram	10,099	1.14

TABLE 2.2

Census Information of 2001: Hindus-Muslims Compared

Composition	Hindus	Muslims
Total Percentage of population	80.5	13.4
Sex ratio*(avg.933)	931	936
Literacy rate (avg. 64.8)	65.1	59.1
Work Participation Rate	40.4	31.3
Rural sex ratio	944	953
Urban sex ratio	894	907
Child sex ratio (0–6 yrs)	925	956

(http://en.wikipedia.org/wiki/Islam_in_India)

The sociological and anthropological studies of Muslims and Islam in India over the last few decades shows that the research interest has got focused on a few selected areas relegating to the background issues of everyday cultural practices among Muslims. Subsequently, there has been a discussion on specific problems in the study of Muslims and Islam in India, such as on the approach to the study of Islam in South Asia and on caste among Muslims (Fazalbuoy, Nasreen 1997, pp-1547-1551).

Another eminent sociologist had noted that by and large sociologists have concerned themselves with Hindus in India, and whether one looked at village studies, or studies on religion or modernization and development, the absence of information on Muslims or for that matter on all the minorities is striking. This situation, while improved, has not much changed (Fazalbuoy, Nasreen, 1997, pp-1547-1551).

Role and Status of Muslim Women in Indian Society

Index of modernization of any society is the position of its women vis-à-vis men. The more balanced the opportunity structure for men and women, the larger the role women have in society and consequently the higher their status. In a developing society, it is essential that both men and women play equal and important role in the development effort. Improvement in the traditional status of women, therefore, is a necessary first step in this programme. Accordingly, the Government has adopted certain measure to enable women to improve their position in society.

None-the-less Muslim women in India have lagged behind in educational attainment and consequently in the process of modernization compared to women in other communities. It is true that the Indian Muslims themselves are backward compared to other communities but while their men have been able to enjoy a fair share of the benefits accruing from the nation's development effort, their women have not been able to do so. It is, therefore reasonable to assume that there may be some social, structural and institutional factors which inhibit women from availing of education and through it the utilization of existing facilities to their maximum advantage. It will be useful to identify these factors in order to have a full view of the magnitude of the problems of raising the status of Muslim women.

If we want to study the status of women in any society, we must study the complexity of roles which women perform in the society in the socio-economic, cultural, religious and political fields. It is also important to find out such factors as how they face the problems and situations that are connected with their sex roles from birth to death and how they adjust themselves to these roles situations (Chaturvedi , Archana, 2004. pp 1-2).

It is very difficult to find out as to what is the status of women in Muslim society, because one billion Muslims may share the same holy text but not the same

tradition and culture. However, despite many contradictions, some disabilities are historically associated with the fairer sex in many Muslim communities such as:

1. Keeping women as keeps and concubines in harems without proper marriage.
2. The time of Nikah.
3. Not giving a chance to be a leader in social life, religious affairs and family matters.
4. Subjecting her to extreme forms of segregation which makes education and employment very difficult for her.
5. Not considering her witness equivalent to male witnesses.
6. Not letting her participate in the political process or contest an election.

Many Muslim countries, excluding a few exceptions, have accepted education and employment for women as part of their way of life. This positive thinking has reduced extreme segregation of sexes and disabilities of women in social mobility. The rest of the Muslim world may too, if they realize that Islam does not make women disabled. There is, therefore, a need to understand and preach the true spirit of Islam (Chaturvedi, Archana, 2004, pp 217-218).

Women status can be analysed in terms of their participation in decision-making, access to opportunities in education, training employment and income. In recent years, there has been an increasing recognition of the interface between women's ability to control their fertility and their exercise and enjoyment of other options in life.

Women development could contribute to the development and modernization of the world. A similar message was conveyed by the UNESCO wherein it observed that women can play an important part in development.

A UN report also supported this view according to which "the exclusion of women from many aspects of the development process also has important indirect effects". These effects may be summarized as follows:

Firstly:-there is the effect on the nature of their influence on the education and socialization of their children, because by and large, women will pass on their own experience and attitudes to the next generation.

Secondly:-there is the indirect effect on population growth. This is an extremely complex subject, though it is not easy to isolate the factors affecting fertility, many of the relevant factors can be combined under the heading of exposure of women to Modernization (Goel, Aruna , 2004. p-4).

Abusuleh Shariff examined the socio-economic and demographic characteristics of population according to religious affiliation in India. According to Shariff, at the outset, it must be emphasized that various religious groups in India, especially Hindus, Muslims and Christians are not homogeneous populations. Each one is divided and subdivided into innumerable castes, sects and cultural groups. The studying of socio-economic differential in India at the level of religious aggregation is complex and not advisable. It is necessary that relevant facts and figures found in the officials and academic records and publications are put together for an objective assessment of reality (Shariff, Abusaleh, 1995, p-2947).

According to Shariff India got independence in 1947 which also led to partition of the country. A large number of Muslims moved over to the then Pakistan. In 1951(the first census after independence) there were 35 million Muslims living in India, forming the largest minority. According to this census there were 304 million Hindus and about 8.3 million Christians in India. The Hindus were the significant majority in all states excepting in Jammu and Kashmir and Punjab, where Muslims and Sikhs respectively out number them. Among the 14 major states, the Christians were found in substantial percentage only in Kerala (Shariff Abusaleh, 1995, p -2948)

Shariff emphasizes that the Socio-economic conditions of a population can be assessed by studying indicators, such as land ownership, occupation, worker population ratio, literacy and school continuation rates. Such data, for the first time have been made available by the National Samples Survey Organization (NSSO) through its 43rd round survey conducted during 1987-88. NSSO is probably the most scientific and dependable source of data on various types of social and economic information for both the states and the national levels (Shariff, Abusaleh, 1995, p - 2948).

The work participation rates for male in both rural and urban areas for all religions are fairly high. The male work participation rates is marginally higher for all religious groups in rural areas. The differentials between religious groups for males are also marginal. The female WPRs are substantially lower in both rural and urban areas. Apart from the lack of work opportunities for females, the cultural factors such as practice of purdah and female seclusion might have affected the female WPRs in India (Shariff, Abusaleh, 1995, p -2949).

Educational Conditions of Muslims

The role of education in facilitating social and economic progress is well accepted today. Improvements in the functional and analytical ability of children and youth through education open up opportunities leading to both individual and group entitlements. Improvements in education are not only expected to enhance efficiency but also argument democratic participation, upgrade health and quality of life.

At the time of adopting the Constitution the Indian state had committed itself to provide elementary education under Article 45 of the Directive Principles of state policy. Article 45 stated that "The state shall endeavor to provide within a period of ten years from the commencement of this Constitution for free and compulsory education for all children until they complete the age of fourteen years". Subsequently in 2002 education as fundamental rights endorsed through the 86th

amendment to the Constitution. However, despite this commitment the number of children in this age group who have remained out of school is alarmingly large (Sachar Committee Report, p-49).

Low level of Education

Education is an area of grave concern for the Muslim Community. The popular perception that religious conservation among Muslims is a major fact for not accessing education is incorrect. The recognition of their educational backwardness is quite acute amongst a large section of Indian Muslims and they wish to rectify it urgently. There is significant internal debate about how this should be done. Private minority institutions and Madaras are seen as the only option available to the Muslim Community. However, others finds these to be questionable alternative pursued by the state neglecting its own responsibility. Relying predominantly on Madarsa and denominational institution for improving the educational status of Muslims was also seen by some as violating the spirit of the Constitution.

POVERTY – The main cause of low level of education

High dropout rates among Muslims students are worrisome. As with many Indians, the main reason for educational backwardness of Muslims is abject poverty due to which children are forced to drop-out after the first few classes. This is particularly true for girls. Little children are expected to provide for their families by working in karkhanas (small workshop), as domestic help or by looking after their siblings while their mothers go to work. It was felt that the incidence of child labour was much higher among Muslims as compared to other SRCs. Poor and illiterate parents cannot afford tuition for their children nor they can provide necessary support system at home which has became so essential a part of today's educational system. The opportunity cost involved in sending children to school is also too high, making it difficult for parents to do so.

The low representation of Muslims in public and private sector employment and the perception of discrimination in securing salaried jobs make them attach less

importance, the formal secular education in comparison to other SRC. At the same time the community, especially the educated Muslim middle class, finds itself frustrated and alienated because of the lack of presence and opportunities in administrative, policy and political space.

Many complained that only a few good quality schools, especially Government school are found in Muslim areas. The teacher pupil ratio is also high in these schools. This forces Muslims children to go to private schools, if they can afford to or else to dropout.

Government Schools that do exist in Muslim neighborhood are merely centres of low quality education for the poor and marginalized. This has a negative impact on retention and school competition. Thus poverty again has a causal link with access to education among Muslims.

The distrust levels can be gauged from the fact that people actually believe that schools in some states have been given instruction to not let Muslim students pass in examination. The transfer of Muslim teachers to schools at a great distance is not uncommon (Sachar Committee Report pp 15-16)

EMPLOYMENT OPPORTUNITIES AND LABOUR MARKET IMPERFECTION

The poor representation of Muslim in the employment market was highlighted over and over again across all states. Despite obtaining degrees and certificates Muslims were unable to get employment especially in the Government and organised sector. The Committee's attention was drawn to the lack of Muslim representation in position of power. The lack of Muslims in public employment in the bureaucracy, police and the judiciary, and so on- has been a matter of great concern. Discriminatory practices, especially at the time of the interview, were cited as reasons for poor Muslim representation even at the class IV level or in Grade D employment where high educational qualification are not required. Muslim representation at the highest level was miniscule; even at the level of the

constabulary Muslim representation was reported to be very low. Because the political participation of Muslims also was limited there are very few to raise a voice in their favour.

Muslim presence in the private sector was found to be even more dismal. It was felt that private sector needed to be sensitized to this issue so that it would include Muslims in their recruitment through positive discrimination and affirmative action (Sachar Committee Report, p-21).

Malini Goyal explained that the first detailed census of Indian citizens based on their faith gives invaluable insights into the religious fabric of the country. But political parities are using the findings for vested interests.

Amidst the politically charged environment, the message is completely lost that the population growth rate is defined more by socio-economic status rather than religion. Economically, Muslims are the most backward community with the lowest employment rate. Their population is rising faster in poor states like Bihar, Jharkhand, Rajasthan, Uttar Pradesh than in the developed states of Tamil Nadu, Kerala, Andhra Pradesh and Karantaka. Growth rates across all communities in prosperous states like Tamil Nadu, Pondicherry and Maharashtra are much below their national average while growth rates in Uttar Pradesh and Rajasthan are substantially higher than the national average across all communities, says Jayant Kumar Banthia, Census Commissioner. "Beyond growth rates, the relogion census sends out a larger message to policy makers on overall developmental needs".

The Census data also reveals that population growth is more a factor of education and literacy. For instance, barring a few blips, Bihar has among the highest fertility rate, the lowest overall literacy rate and one of the poorest employment rates across all communities. In contrast, Kerala has among the highest literacy levels including women, the lowest fertility rate and among the best sex ratio across all communities. Little wonder then that Bihar's population grew at as faster clip than

that of Kerala. Jains have the highest literacy levels and the lowest fertility rate in the country.

Education is the process that liberates mind. It is liberation from all forms of darkness and ignorance. Women's literacy is essential for economic viability and independence. Acquisition of knowledge is one of the prerequisites of human development. Today all development agencies agree on the importance of educating women in order to promote and maintain family education, health, nutrition and general well being. The aim of education should be to train women in such a way that they apply their acquired knowledge to the pursuits of daily life and fit them for the position they have to fill.

The University Education Commission (1948-49) just after Independence felt the need of women's education and stated that, "there cannot be educated people without educated women. If general education has to be limited to men or women, that opportunity should be given to women, for then it would most surely be passed on to the next generation". On the other hand, female education has been found to have a more significant effect on poverty reduction and promotion of sustainable development by influencing family size and female labour force participation. (Pandya Rameshwari, 2008. p- 65)

Shariff Abusaleh has quoted the NSS data for (1987-88), that present information about the levels of education achieved by males and females according to religious categories. It was found that in rural areas christians are more educated as compared to others. Similarly, among all religion categories males are comparatively more educated. While illiteracy among Muslim men is 58%, it is 51% among the Hindus and only 34% among the Christians. For females, respective percentages of illiteracy is 76%, 75% and 43% . Christian retain their lead even in higher education categories, for example, 9% of Christians males and 8% of females are secondary educated, whereas the figures for the Hindus and the Muslims males and females are 5.7% and 1.7% and 3.4% and 0.8% respectively. Further while negligible proportion of Muslims females and 0.6% of Muslims males are found in

graduate and above categories, these proportion are 0.2% and 1.2% for Hindus, and 1.5% and 1.8% for Christian.

The male illiteracy in urban areas are only 19%, 25%, 42% for Christians, Hindus and Muslims respectively and female illiterates are 23%, 42% and 59% respectively. Literacy rates at the Secondary Education level in the same ordered are as follows: 20%, 17% and 8% for males and for females 21%, 11%, and 4%. Higher educated proportion are relatively better among Christians and Hindus males, 8% each but only 2.3% Muslim males are reported to be graduate and above. The achievement among female, 5.5% among Christians, 4.2% among Hindus and only 0.8% among Muslims. Thus in terms of all the Socio-economic parameters discussed above Muslims are relatively worse off than Hindus and Christian in both rural and urban areas of the Country (Shariff, Abusaleh, 1994. pp 377-78).

Jawahar Lal Nehru in his autobiography has stated that Sir Syed's decision to concentrate on western education for Muslim was undoubtedly a right one. Without that they could not have played any effective part in building up of Indian nationalism of the new type and they would have been doomed to play second fiddle to the Hindus with their better education and for stronger economic position (Chakarbarti Debashis, 1995. p-9).

The Creation of Pakistan left India's millions of Muslims in a state of psychological tensions and confusions. A large number of educated middle class Muslim from Northern India and Interprenual class from Bombay, Gujarat and Calcutta migrated to Pakistan, as did the politically conscious Muslims elites, leaving behind millions of their poor co-religionists(land less laborers, cultivators, slum dwellers and the like), without either leaders or a well knit political organization. But the shock of partition and military operation against Hyderabad state (1947-1948, respectively) is over now, and the Muslims community is coming out of its post independent daze (Khalidi, Omar, 1995, p-2).

Anis Ansari(1992) has reported that Muslims in India constitute one of the most backward sections of the society, along with the neo-Buddhists, and Schedule Castes and Tribes, etc., in terms of both the educational spread and the quality of performance. The New Education Policy 1986 justifies this fact and declares that greater attention will be paid to the education of these groups in the interest of quality and social justices.

According to Ansari different causes of educational backwardness of Muslim Community can be summarized as follows:

1. Religious orthodoxy and cultural ethos of Muslims.
2. Muslim perception of discrimination in job.
3. Feeling of irrelevance of modern education to their present occupational roles.
4. Sense of insecurity due to communal riots.
5. Lack of competitive spirit in Urdu medium schools.
6. Little stress of Muslims leaders to reduce the educational backwardness of the Community.
7. Migration of educated middle class Muslim to Pakistan.

Ansari further states that the main reason for relatively low income level of Muslim households was their heavy concentration in less remunerative occupations. A very low percentage of Muslim household is engaged in professional administrative and clerical jobs and a high percentage is dependent on household based cottage industries. Muslims are very poorly represented in the top 10% of the population. Thus the under representation of Muslims in educational sphere can be explained to a large measure by the small size of social stratum among them (Ansari, Anis, 1992. pp-2289-91)

Political Participation

Political participation is another indicator of a community's empowerment. In a democracy, the legislature is the fountain head of power. The fact is that the Muslim community is inadequately or simply not represented in several legislatures and even in the Lok Sabha, its representation is less than 50 percent of what it should be, assessed as per the share in the population. Besides being an alienating experience, absence of legislators from any social group in a plural & segmented society puts that group at a clear disadvantage. The role of the MP or the MLA in promoting the development of his constituency cannot be ever emphasized. The community interests can be brought centre stage with the help of the respective Members of Parliament. This is a natural legitimate expectation. Hence for any development or welfare programme to reach out to a deprived and backward community and not get diluted or lost in the bureaucratic maze, demands due representation in the legislatures. How this can be brought about, by reservation as in the case of SCs/STs or by changing the present electoral system and adopting proportional representation or through sympathetic action by political parties needs to be given serious thought and details worked out. However, it needs to be pointed out that without political empowerment, any development or welfare schemes for the Muslims will at best remain token schemes and as far as the general schemes go, what share the Muslim community will receive in the fruits of development is anybody's guess.

In a recent study on political representation of Indian Muslims in post-colonial India, Iqbal Ansari (2006) has argued that Muslims are not adequately represented in the legislative bodies. This study, for instance, reveals that Muslim representation has not been satisfactory in the Parliament (see Table2.3). Except for the 1980 and 1984 Lok Sabhas, Muslim under-representation, or what Ansari calls *Muslim political deprivation*, remains around 50%.

TABLE 2.3

Muslims in Lok Sabha					
No.	*Year*	*Total elected members*	*Muslims elected*	*Expected representation on population basis*	*Deprivation %*
I	1952	489	21	49	57.14
II	1957	494	24	49	51.02
III	1962	494	23	53	56.60
IV	1967	520	29	56	48.21
V	1971	518	30	58	48.28
VI	1977	542	34**	61	44.26
VII	1980	529*[1]	49**	59	16.95
VIII	1984	542	46**	62	25.81
IX	1989	529*[2]	33	60	45.00
X	1991	534*[3]	28	65	56.92
XI	1996	543	28	66	57.56
XII	1998	543	29	66	56.06
XIII	1999	543	32	66	51.52
XIV	2004	543	36	66	45.45
Total			442	836	47.12

Notes: *1: Elections were not held in Assam (12) and Meghalaya (1); *2: Elections were not held in Assam (14); *3: Elections were not held in J&K (6) and countermanded in two seats in Bihar and one in UP.**

Including Muslims elected in bye-elections.

Source: Ansari 2006, p. 64.

Ansari points out that those political parties are mainly responsible for Muslim political deprivation. He shows that almost all major political parties failed to nominate Muslims for Lok Sabha elections (Table 2.4). Analysing these trends, Ansari concludes that the present electoral mechanism system is inadequate because it does not provide proportional representation to Muslims. Therefore, some kind of alternative should be worked out.

TABLE 2.4

Nomination of Muslims for the Lok Sabha Elections by Major Political Parties

Name of the political party	*Average nomination*	*Ratio: elected to nominated*
INC	6.72%	1:2
BJS/BJP	0.82%	1:10
CPI	4.24%	1:9
CPI(M)	9.34%	1:2
Janata Party/Lok Dal	6.8%	1:5
Janata Dal	9.04%	1:4
RJD	14.79%	1:4
SP	18.02%	1:7
BSP	10.53%	1:17

Source: Based on Ansari 2006, 99-102.

Ansari suggests three main avenues for increasing Muslim representation: (*a*) 'All political parties nominate a fair share of minority candidates under the People's Representation Act ...at least making parties accountable for any persistent under-representation of minorities. (*b*) De-reserving those constituencies reserved for SC which have a good percentage of Muslim voters. Alternately, the category of SC should be defined in terms of social origin, irrespective of faith, allowing Muslims and Christian Dalits to seek election from seats reserved for SC. (*c*) Redrawing constituencies with a view to enabling under-represented groups like Muslims' (Iqbal A. Ansari, 2006).

These recent developments have changed the nature of debate on Muslim political representation. Merely calculating the number of Muslim MPs and MLAs can no longer solve this vexed question in the country/or concerned state. In contrast, the focus is on the sociological complexities of Muslim communities and their political assertions in relation to the responsiveness of political institutions. Thus, in order to map out the various trends of the debate on Muslim representation in contemporary India, one needs a systematic analysis of various positions, perspectives, issues and concerns

A number of Muslim women were able to successfully make the transition from social activism to politics during this period. However, they entered political life at a time when communal identities were becoming more crystallized, and thus instead of being able to unite on issues concerning women, which they had cooperated on earlier within women's organizations, they spent most of their energy debating communally sensitive issues in the legislatures, and sometimes even employing gender stereotypes to propagate communal differences. At the same time as women were given increased political rights of franchise and representation, their potential strength as an interest group had been destroyed by the principle of communal representation, which forced women to become representatives of their respective communities rather than of all women (Hasan and Menon,2005, p 231).

For the majority of Muslim women who have become involved in politics, politics has been the culmination of a career that has frequently involved some kind

of social service. As was the case in the pre-independence era, women first become active in local women's or charitable group before moving on to the wider world of politics. This discernible pattern in line with global trends as examined by the Inter-Parliamentary Union. The IPU notes that it is quite common for women to be involved with social work as a channel to entering politics, adds that the female politicians that it has surveyed frequently gain practical, on-the-job experience that can help prepare them for a life in politics through involvement with non-governmental organizations, the women's movement, or trade unions(Hasan and Menon,2005, p 250).

Economic Condition

The low socio-economic status of Muslims is now well-known; like scheduled castes, they are disproportionately represented among the poor and have the lowest per capita income indicators. This is ascribed not only to lack of access to asset ownership, but also to poor educational attainment and occupational patterns which show clustering in low paid activities, as well as the concentration of the Muslim population in the economically backward regions of the country.

This economic differentiation constitutes probably the primary source of differentiation in status between Muslim and Hindu women in the aggregate, since the household's level of assets ownership, occupation and income possibilities critically determine the basic conditions of life of the women. However, there are significant regional differences in this: Muslims are generally poor in the north (especially rural areas) and east, but less so in the south.

It is well known that the work participation of Muslim women is very low, but the studies indicates that this may be less due to the force of religion *per se* than to the patriarchal structures and patterns as well as low mobility and lack of opportunity that define their lives. It is worth noting that the work participation rate of women across communities tends to be low in certain regions, especially in the north and the east.

Some of this is due to straightforward control over women's agency by male members of the household. Seventy five per cent of the women in the survey (both Hindu and Muslim) reported that they need permission from their husbands to work outside the home. Interestingly, the study revealed that across the board women in India tend to have relatively less autonomy of decision-making within the household.

In a study conducted by Jayati Ghosh (2004), less than 10 per cent of the respondents took any decisions on their own in major or minor matters, and among the 30 per cent who took decisions jointly with their husbands. Muslim women reported greater consultation than Hindus for all categories of decisions. Clearly, however, patriarchal control remains one important constraint upon the outside work of women, among Muslims as well as certain other social categories.

But in addition, most of the outside work that the representative Muslim woman has access to falls in the lowest paid and most exploited categories of labour. Such activities - self-employed in low-productivity activities in the informal sector, as casual labourers and domestic servants - imply poor working conditions and low wages. It is, therefore, possible that Muslim women are kept out of the paid workforce not only by religious or *purdah* type motivations, but perhaps more significantly by low education, lack of opportunity, low mobility and the inability to delegate domestic responsibilities (Jayati Ghosh,2004).

Women are oppressed not so much by religion as by society. In order to bring about change in the plight of Muslim women it would be equally necessary to bring about change in socio-economic conditions of Muslims in India. If Muslims remain poor and illiterate, it will be very difficult to improve conditions of Muslim women (Engineer,Asghar Ali,2005, p149).

India development planning has always aimed at removing inequities in the process of development to ensure that the fruits of development are an equal privilege of all. In recent years it has become increasingly evident that women are lagging behind a great deal both in availing of the benefits of development as participants in the process of development due to several socio-economic-cultural-

political impediments. This has become a cause for concern since women number several millions and constitute nearly half our population (Sahay, Sushama,1998, p-157).

The problem of for women workers is accentuated by the patriarchal ideology operating behind the data gathering system in which the conceptual understanding of women's work is faulty. Since the system of census records was introduced by British rulers in India it is based on the premises that 'men are workers women are dependent'. The leaders and intellectuals connected with the planning process of the economy in independent India also had the same upper and middle-class world view which saw women as dependent on men. They simply ignored the reality of masses of working women in poor urban and rural families.

Some positive attempts are made to make the census data closer to the real estimate of women's work in the recent censuses but it is yet to become an inherent part of the data collection system as such. But it is a long way to go since women are not recorded workers; they remain invisible and their contribution unrecognized. The implications for women's empowerment are obvious (Pandya, Rameshwari, 2008, p-268).

Women in our country constitute 48.5 per cent of the total population. Development of Indian economy cannot be possible neglecting the women who are large segment of Indian population. If the development programmes can be able to successfully utilize the women force then the total development will be easy and sex discrimination, economic oppression and social stratification can be removed. That's why the challenges are to ensure women's development through economic empowerment and self reliance to the women. The Government has taken a number of measures in this direction for social and economic enlistment of women. Some measures for enlistment of women like employment and income generation activities including self employment with training for up gradation of skills supported by welfare have been taken by the Government (Ganesamurthy V.S.,2008, p-59).

The socio-economic development of a country cannot be fully realized so long as its women are confined to subordinate position and their talents remain unexplored. Women entrepreneurship are becoming a reality now days due to pull and push factors. Between the pull push factors, the former takes it as real challenges with an urge to do something new and take up an independent occupation. The other category of women establishes business enterprises to overcome the financial problems of self and family. Over the years, the phenomenon of entrepreneurship is largely confined only to metropolitan cities and big towns in India. In order to achieve the objective of social justice, it is necessary to harness the latent skills potentials of women, especially the rural women. They play a key role for rapid and sustained economic development of the rural areas and the ultimate prosperity and development of the nation. Though the central and state governments have launched many entrepreneurial development programmes especially for women, there are no remarkable achievements in rural areas (Ganesamurthy V.S., 2008, p-55).

Economic necessity or other considerations compel women to work, which may lead to psychosomatic symptoms like gastrointestinal problems, depression, stress and headaches which in turn adversely affect the health of their domestic life. Now working women are hit by a speed up syndrome. There is wage variation and leisure gap between men and women. Woman is the one character around which the stability, peace, and prosperity of the family and human civilization on the whole resolve. All Governments and UNO are concerned on the plight of women and promises remain unfulfilled. Existing laws are biased against women's interests in matters like property, marriage and divorce. It is better to form representative bodies of the people at the village level on the pattern of Karnataka and West Bengal so that leakages from developmental funds could be minimized. Priority should be given to land reforms and to households headed by women. Constitutionally women have moved ahead but socially, politically and economically have not caught up as yet.

Women who participate economically in the informal sector (70% of agricultural labour)and produce 90% of food. Women employment is poorly paid or unskilled job ghettoes characterized by the absence of upward mobility and opportunity. Internationally women are most often concentrated in feminized professions termed as horizontal occupational segregation where they tend to remain in lower job categories than men (Raju, Lakshmipathi,2007,pp-147-148).

Health Condition

Women and men share many health problems but women also have their own health issues, which deserve special consideration. Historically, life was particularly difficult for most women. The World Health Organization committed to the health and nutritional wellbeing of women, particularly in the developing countries and has taken keen interest in joining force with all women's advocates and women's organization in advancing their cause, particularly their health and nutritional needs (Ganesamurthy V.S.,2008, p-277)

India is most populous country and in world-wide it is second. Of that number, 120 million are women who live in poverty. India is one of the few countries where males significantly outnumber females, and this imbalance has increased over time. India's maternal mortality rates in rural areas are among the worlds highest. From a global perspective, India accounts for 19 percent of all infant deaths and 27 percent of all maternal deaths.

The persistence of hunger and object poverty in India and other parts of the world is due in large measure to the subjugation, marginalization and disempowerment of women. Women should bear the primary responsibility for actions needed to end hunger and promote education, nutrition, health and family income.

Definition of Health

Health is a state of complete physical mental and social well-being and not merely the absence of disease and infirmity; Health is both an important factor in the achievement of status as well as an indicator of social status, particularly for women, whose health is conditioned to a great extent by social attitudes. The health status of women includes their biological and physiological problems. Society delineates women's roles partly according to their biological function and partly from prevailing attitudes regarding their physical and mental capacity (Raju, Lakshmipathi,2007,pp-113-114).

Nutritional Requirements for Women

Woman needs a wide range of nutrients to perform various functions in the body and to lead a healthy life. During adulthood nutrients are required for the purpose of energy, for replacement of worn-out tissues and maintenance of body functions. Though there is no growth during adulthood, protein is required for the replacement of worn-out tissues. The nutritional requirement of other age groups is sometimes extrapolated from adults' requirement.

On the other side of the spectrum of malnutrition, diet related non-communicable diseases are commonly seen. With increasing urbanization, energy-rich diets containing higher amounts of fat and sugar, which also provide less dietary fibre and complex carbohydrates, are being consumed, particularly in high-income groups. In addition, the urban population is tending to be more sedentary with little physical activity. Hence prevalence of disorders like obesity, heart disease, hypertension and diabetes is on the increase.

Women's Status and Women's Health

Women's poor health is a reflection of their low status in many developing countries. Worldwide, women have a longer life expectancy than men [but] despite

this, females have higher morbidity and physical disability levels than males throughout the life cycle.

Women's lack of education and disadvantaged social position help perpetuate poor health and high fertility, as well as a continued cycle of poverty. Because women tend to be less educated and have less access to information, they are less apt to recognize problems or understand the value of or seek out preventive and curative care. Among other benefits, female education, especially through the secondary level, is associated with greater use of contraception and increased age of marriage, both of which improve women's health by reducing their exposure to pregnancy and early childbearing.

The health of women is integrally related to their overall status in society. Expanded opportunities in health and education will allow women greater control over their health and lives enable them to exercise more productive and visible roles in socio-economic development (Ganesamurthy V.S.,2008, pp-158-159).

The average female life expectancy today in India is low compared to many countries, but it has shown gradual improvement over the years. In many families, especially rural ones, the girls and women face nutritional discrimination within the family, and are anaemic and malnourished (Women in India, from Wikipedia, the free encyclopedia).

Women are the foundation upon which the family and society are built. Their bodies are the bed rock that supports civilization. Just as the foundation of a house must be perfectly strong, women bodies and their health should be of perfectly balanced.

REFERENCES

1. Shariff, Abusaleh. (1994), "Socio-Economic Differentials among population of various religious",*Muslim India*, No.140, pp. 377-78

2. Shariff, Abusaleh. (1995), "Socio-Economic and Demographic Differentials between Hindus and Muslims in India", *Economic and Political Weekly*, Vol. 30, No. 46, November 18, pp.2947-2953

3. Ahmad, Aijazuddin. (1996),"*Muslims in India*", New Delhi, Inter India Publication, pp. 39-40.

4. Ansari, Anis. (1992), "Educational Backwardness of Muslims", Economic and Political Weekly, Vol. 27, No.42, October 17, pp 2289-91

5. Ansari, Iabal,A. (2006),PoliticalRepresentation of Muslims of India: 1952-2004, Manak, Delhi

6. Chakarbarti, Debashis. (1995), "Harbinger of Reforms", The Pioneer, New Delhi, p.9

7. Chaturvedi, Archna (2004), "*Muslim women and society*", New Delhi Common wealth Publisher, pp.1-2.

8. Engineer, Asghar, Ali.(2003), "Muslim Minority (Continuity and Change", Gyan Publishing House, New Delhi, p. 149

Fazalbhoy, Nasreen. (1997), "Sociology of Muslims in India", *Economic and Political Weekly*, Vol.XXXII, No. 26, June 28, pp. 1547-1551.

9. Ganeshmurthy V.,S.(ed.),(2008)," Empowerment of Women in India (Social, Economic and political), New Century Publications, New Delhi, pp. 4-5

10. Ghosh, Jayati. (2004)," Muslims Women in India", Frontline, Vol.21, Issue-19, September 17

11. Goel, Aruna. (2004), *"Violence and Protective Measures for Women Development and Empowerment"*, New Delhi, Deep & Deep Publications PVT. LTD., pp.3-4.

12. Khalidi, Omar. (1995) "Indian Muslims Since Independence", New Delhi, Vikas Publication, pp-2

13. Hasan, Zoya & Menon, Ritu. (2005), "Unequal Citizen" Oxford University Press, New Delhi, p. 231

14. Khalidi, Omar. (1995) "Indian Muslims Since Independence", New Delhi, Vikas Publication, pp-2

15. Mudurani, Lakshmipathi, Raju.(ed.), (2007),"Women Empowerment, Challenges and Strategies" Regal Publication, New Delhi, pp.113-148

16. Pandya, Rameshwari.(ed.), (2008), "Women Welfare & Empowerment in India), New Delhi, New Century Publication, pp.65

17. Rehman, Zainab. (2005), "Women and Society", New Delhi, Kalpaz Publication, pp.81.

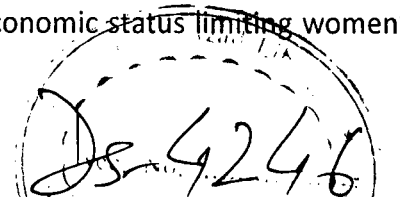
18. Sahay, Sushma.(1998), Women and Empowerment(Approaches And Strategies), Discovery publishing house, New Delhi,p-151

CHAPTER- 3

HEALTH CONDITIONS OF MUSLIM WOMEN IN NORTH INDIA

India launched the National Family Welfare Programme in 1951 with the objective of reducing the birth rate to the extent necessary to stabilize the population, consistent with the requirements of the national economy. Since its inception, the programme has experienced significant growth in terms of financial investment, service delivery points, type of services, and the range of contraceptive methods offered. Since October 1997, the services and interventions under the Family Welfare Programme and the Child Survival and Safe Motherhood Programme have been integrated with the Reproductive and Child Health Programme.

The status of women's health is largely reflected by the indicators like female mortality and morbidity, disease burden, reproductive health and reproductive behaviour, contraception, abortion, maternal mortality and morbidity, gynecological morbidity, infertility, nutrition, work environment and health covering aspects like poor sanitation, air pollution, poor quality of housing, degradation of natural resources, sexual harassment and health problems related to nature of women's productive work and violence against women and its consequences for the health care system of women. The health profile clearly demonstrates that the situation is far from satisfactory. Malnutrition, often caused by the gender discrimination in food distribution, presents a serious threat to health of girls and women. Discriminating child care leads to malnutrition and impaired physical development of the girls. Under nutrition and micro-nutrient deficiencies result due to discrimination in food entitlement. Women's risk of premature death and disability, is higher during their reproductive years. MMR and IMR coupled with educational backwardness of women, results in low social and economic status limiting women's access to



education, good nutrition, family planning services and health care. The main factors determining women's health, are :-

1. Restrictions on physical mobility
2. : Marriage
3. Divorce
4. Inheritance
5. Literacy, School Enrollment and Drop-Out rate

Maya Unnithan Kumar (1999) examined that the reproductive health care in the context of Muslim women's perceptions and experiences in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations. A study of the rural Nagori Sunni community in Jaipur district, Rajasthan was carried out in Sanganer tehsil which has a population of 8,404 Muslims out of the 3,81,214 Muslims in the district as a whole. The material is based on two Sunni, Nagori Muslim dominated village in the north-eastern part of the tehsil. The Nagori Muslim men and women in Sanganer do not entertain the idea of a control on conception, nevertheless at an individual level; they seek out health services for sterilization as well as the medical termination of pregnancies (Kumar, Maya, Unnithan, 1999, pp-621).

Reproductive health practices among Muslim women in India had been little researched perhaps because of the wide-spread notion regarding the tight Islamic control over sexual behavior and the sanctions against contraceptive use. It focuses on menusuration and childbirth and local perceptions of the body, reproduction and ill health. It describes the material and ideological factors linked to the household which facilitate Nagori women's use of health care services.

Most of the reproductive problems of women in the area of Jaipur district were related to mensuration. While a few cases of maternal mortality came to

the notice of the health centre, there was a high incidence of maternal morbidity. This ties in with various statistics on Muslim women's health which show a high occurrence of maternal morbidity and disease of women in their reproductive life span with a high correlation between poverty and maternal and infant mortality. As is well known, infant mortality is crucially connected to maternal health, high infant mortality figures are recorded in Rajasthan in general. There was very high incidence of foetal and infant mortality across communities in the area with the highest number of children dying below one year.

As women articulate their health problems in very general terms, it is important to consider women's reproductive health in the context of their wider complaints of illness. Nagori and indeed other caste women used descriptive terms such as pain, discomfort to convey their sense of ill-being. The most frequent general complaints of Muslim women, in order of highest occurrence are: (i) pain in the upper abdomen related to hyperacidity, with nearly four to five out of every 10 women having this complaints. (ii) dizzinesss along with loss of appetite, related to weakness and malnutrition; (iii) chronic cough, a common ailment which they share with men; (iv) fevers and body aches the latter affecting older women more frequently; and (v) others, such as headaches and visual disturbances, seasonal diarrhoea, fungal skin infections and viral fevers. The use of more general words relating to pain, discomfort and weakness rather than specific disease related terms also points to the fact that women perceive their illness as related to causes lying outside the purely physiological domain.

The high maternal morbidity among rural Muslim and Hindu caste women was related to a combination of physiological, social, economic and psychological factors wherein marital problems, the social consequences of aborted fertility, poverty and lack of nutrition, the inability to control infant mortality, the lack of information about diseases and effective recourse to cures were only some of the realities which took their toll on women's lives (Kumar, Maya, Unnithan, 1999, pp-621-622).

The sexual division of household labour and further the division of labour among women of the household has implications for Muslim women's health at two levels. Firstly, in terms of the actual physical burden imposed by hard and continuous labour with little respite during weakness or illness. Secondly, the continuous daily demands made on women's time makes it very difficult for them to take 'time out' to consult health specialists. This direct and indirect toll on women's health shifts with the development cycle of the household being heaviest on newly married women, somewhat less burdensome when children become old enough to help (from seven to 10 years onwards) and significantly reduce with the arrival of daughters-in-law. The desire of women to have children, daughters to help at home when they are young and sons to bring in their wives' labour, works significantly towards achieving a reduction in their work burden. In this sense there is a conflation of the cultural notion of having more children (where no active decisions may be taken) and the desire for offspring to meet labour demands (where active decisions to have more children are taken) (p-623).

The weakness of mothers and infants is largely due to their under-nourishment and connected with little emphasis on the quantity and nature of the dietary intake of mothers during pregnancy and after childbirth. Nagori Muslim women ate no differently in quantity or type of food during their pregnancy compared to what they would eat under normal circumstances. This means they would have a cup of tea in the morning, approximately one to two rotis with one 'Katori' (small bowl) of cooked vegetables or chutney or chilli; onions and one katori of buttermilk/dal or lentils at mid-day and the same at night. Most men were unaware that women needed any supplements to their food or even respite from work during their pregnancy. A few women mentioned that it was a good idea to eat ¼ kg to 1kg of 'khopra', 0.5 kg urad lentils and up to 1.5kg of sesame seed oil in the eighth month as these are lubricating foods which would help the foetus move easily within the womb to ensure a smooth delivery. Almost all women reported having some special food after childbirth but the

quantities were little and the duration was on an average up to 20 days after delivery.

Women themselves did not consider it important to change the type or quantity of foods during pregnancy or lactation. A number of women said they were incapable of ingesting much food under normal circumstances as well. This may very well be the case as in anaemic conditions, due to a reduced oxidation of the body, there tends to be a loss of appetite. But as one women pointed out, this could have its roots in childhood eating habits. Also , women were afraid to become fat as this would invite comments from other women that they were not working enough. Compared to the women, men in the household ate the same food ('roti-subzi') but in greater quantities, with greater regularity and before rather than after physical labour.

Nagori Muslim women, kumar found, also can directly control conception by opting for (i) foetus extermination (safai) rather than foetus saving techniques, (ii) by resorting to sterilization and, (iii) indirectly by regulating the duration of breast-feeding. While Nagori women have greatest control over beast feeding compared to safai and sterilization, they do not make a direct connection between reduced breast-feeding and the resumption of mensuration (or the ability to conceive). In fact they believe the reverse occurs, in other words, because they conceive, breastmilk production declines. Moreover, their control over breast-feeding is compromised by their weakness and malnutrition (pp 624-626).

Women were quite open in talking about the 'operation' (sterilization), both as something they wanted done and as having undergone it. When he recounted a story he had heard to a group of Nagori women, that women who underwent sterilization before conceiving all the children written in their destiny would be troubled in their coffins by these unborn children, the women laughed. Jabunnisa scoffed and said "who is there to check on what happens in the coffin". The decision to undergo sterilization is one of the couples rather than the

women alone and thus depends on men's attitudes as well. Several Nagori men, unlike Shakila's husband, have had a positive attitude to sterilization either having undergone it themselves or have encouraged their wives to be 'operated'. Nagori women's agency must also be seen in terms of the different attitudes and social hierarchies (especially of poverty and Quranic education) which exist between men. It was often the case that men who were well versed in the Koran and read it daily placed greater strictures on their women as a means of differentiating themselves from other men in the community.

Much of the demographic literature had been on the impact of schooling and employment on women's powers to take autonomous decisions regarding their fertility. Yet as Jeffrey and Jaffrey's study of Muslim Sheikh women in Bijnor, UP suggests, that while there is a correlation between lowered fertility and women's schooling experience, and work outside the home, it is not always so (1997: 121). On the other hand, there was a woman who along with her husband was one of the two young couples who use nirodh. On the other hand, there was a women who would like to have an abortion to space her children but who cannot do so because of her husband wishes against it. Then there was another women who has had neither a Quranic nor any other education, was relatively poor and uses the Copper-T. (pp-627).

The material on Nagori Muslim women emphasizes the fact that the extent to which they can be active agents in health care matters depends, apart from their own motivation, on their physical condition (with weakness acting as a constraint upon their activities), their vulnerability to cultural notions (which especially young and first time mothers are prone to), their age, household relationships especially with the husband and the women in his family and the interhousehold connections.

Aarzoo & Afzal (2006) used the 1998–1999 Indian National Family Health Survey of ever-married women in the reproductive age group and analyzed the data of north India like Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh

(*n*=11,369). Overall, about three-fifths of rural women did not receive any antenatal check-up during their last pregnancy. Services actually received were predominantly provision of tetanus toxoid vaccination and supply of iron and folic acid tablets. Only about 13% of pregnant women had their blood pressure checked and a blood test done at least once. Women visited by health workers received fewer services compared to women who visited a health facility. Home visits were biased towards households with a better standard of living. There was significant under-utilization of nurse/midwives in the provision of antenatal services and doctors were often the lead providers. The average number of antenatal visits reported in this study was 2.4 and most visits were in the second trimester. Higher social and economic status was associated with increased chances of receiving an antenatal check-up, and of receiving specific components including blood pressure measurement, a blood test and urine testing but not the obstetric physical examination, which was however linked to ever-use of family planning and the education of women and their husbands. Thus, pregnant women from poor and uneducated backgrounds with at least one child were the least likely to receive antenatal check-ups and services in the four large north Indian states. Basic antenatal care components are effective means to prevent a range of pregnancy complications and reduce maternal mortality.

Ara, Nisa, Siddique & Afzal (2006) examined the maternal age and ethnicity in determining demography and selection intensity parameters among North Indian Muslims. They said that reproductive fitness is best studied by taking together a number of parameters like the mean number of offspring produced, pre- adolescent mortality rate, sex ratio and the rate of selection intensity. The Muslims of Aligarh city are predominantly Sunnis, though a considerable number of Shias are also there. In the present study we have reported incidence of marriage, reproductive fitness, mortality and selection forces operative among women of high rank (Ashraf) and low rank (Ajlaf) of Muslims in the northern region .Maternal age was scored as above 45 and below 45 among each of the biradaris. Significant effects of maternal age were seen on fertility, mortality, and sterility and secondary sex ratio of the offspring, whereas

populations did not show consistent difference except between Ashraf and Ajlaf taken separately.

Reproductive behavior of a population is a major attribute of its lifecycle which affects the overall demographic pattern of the population. The reproductive performance includes all the facets of reproductive cycle from menarche to menopause, estimating the rates of conceptions, foetal loss, neonatal, juvenile and adolescent deaths etc. Reproductive fitness, on the other hand, is best studied by taking together a number of parameters like the mean number of offspring produced, pre-adolescent mortality rate, sex ratio and the rate of selection intensity.

Distribution of mothers of different ages in different populations for reproductive fitness study among Ashraf mothers, Syeds are highest for all the age groups (24%) while Pathans are the highest in above 45 years of age (19%), again among Ajlafs, Ansaris dominate in all age group, while Qureshis follow the same in above 45 years of age groups. The lower percentage in the late age group is mainly due to the result of higher mortality of women in the Indian subcontinent, an indicator of underdeveloped country and the lower socioeconomic status. As majority of the women belonged to non-consanguineous cases, these were included only in the study.

In women of above 45 years of age group, the mean fertility value ranges from 5.33 (sheikh) to 7.0 (Qureshi), in the age below 45 year, it ranges from 3.16 (Qureshi) to 4.9 (Sheikh) while in the combined age group it ranges from 4.69 (Syed) to 5.71 (Saifi). On the whole Ajlaf is found to be more fertile than Ashraf.

There is a higher mortality in offspring of higher age women; being lowest among the lower age group, female mortality is lower among the female children, again the Ashrafs have higher mortality than the Ajlaf. Among Ashraf, Sheikhs have the highest mortality and Syeds have the lowest. Among Ajlafs,

Ansaris have highest mortality and Qureshis have the lowest. Qureshis have lowest mortality in all age groups.

The Muslim Women's Survey (2000-01), was carried out in 12 states, spread over 40 districts in India. Convened by Zoya Hasan and Ritu Menon (2000-01), it surveyed 9,541 Muslim and Hindu women respondents -- 80 per cent Muslim and 20 per cent Hindu; and 60 per cent urban, 40 per cent rural. A woman's educational level does not seem to have an impact on her decision making, either for better or for worse. But her socio-economic status has a negative correlation with a rise in economic status: the higher the status, the lower a woman's decision-making powers.

There does seem to be a generational shift, though, with younger women reporting greater decision-making abilities. Rural women report the lowest levels, as do women from eastern parts of the country. The western region reports the highest levels, urban and rural, as concerns decision-making.

Over 50 per cent of respondents said they were consulted about all decisions regarding household and consumption expenditure, marriage and birth and death ceremonies. This consultation, however, declines noticeably with regard to major illnesses, major purchases and investments, and travel.

The significant community difference here is that Muslim women report greater consultation than Hindus for all categories, especially for major purchases and investments.

Given the central role of marriage and motherhood in the lives of Indian women, the question of decisions regarding family size is important. The question posed to respondents was: Have you and your husband ever discussed the number of children you would like to have? All-India, a rather high 56 per cent said they had; 43 per cent said no.

A clear generational shift is evident in the responses: 62 per cent of women in the 18-35-year age group said yes, as did 46 per cent in the 35-40-year age group. Only 14 per cent among the 60-90-year-olds agreed.

Conforming to the usual pattern, urban women report greater discussion than rural women. The survey found a positive correlation between education and marital communication, even in rural India.

Decisions about how many children to have are, on the whole, taken jointly by the couples themselves, in 38 per cent of the cases, and by the husbands alone in 30 per cent. The sharp and significant difference is in the proportion of 'husbands alone' and 'wives alone' deciding -- 30 per cent compared to 2.5 per cent.

The fact that joint decision-making is slightly higher than unilateral decisions taken by husbands is a positive indicator. But it does not necessarily follow that women are equal partners in decision-making or that they have any real choice in the matter.

Badaruddoza, Afzal and Akhtaruzzaman (2006), performed a study in six mohallahs (colonies) of Aligarh City (North India). All six mohallahs are predominantly inhabited by Qureshi (meat sellers, a highly endogamous group) Muslims. A total of 1721 infants and children up to the age of 6 years were examined to determine the incidence of congenital heart diseases (CHD) in relation to the degree of consanguinity of the parents. Around 43% of the subjects were the offspring of consanguineous marriages including second-cousin, first-cousin-once-removed and first-cousin. A higher percentage of CHD was found in the offspring of consanguineous marriages: about 3.37% out of 741 children as compared to 1.22% in 980 offspring of non-consanguineous marriages, whereas in the first-cousin offspring, the percentage of CHD rose to 4.41%. The differences were found to be statistically significant. The present study suggests a genetic influence and also casts doubt on the applicability of a polygenic threshold model to all forms of cardiac malformation.

Jeffrey and Jaffrey's (1997) study of two villages in Bijnor, UP (one is Muslims and one is Hindus) suggests, both villages have expanded rapidly (over 3% per year) although fertility has dropped by 13% in the Hindu village and by 1.5% in the Muslim village. Demographic pressure on the land and increased expenditures connected with consumerism are associated with more out-migration of young men in search of off-farm incomes. Schooling is increasingly important in structuring and reproducing social inequalities, but few poor women (whether Hindu or Muslim) have high levels of schooling.

Liberalisation and the creeping privatisation of health services have accelerated since 1992, and the poor quality government health services of 1982-83 have deteriorated further. Villagers do not use the run-down government health services for maternity care and poor women-especially from ex-Untouchable groups and Muslims-are inhibited from using government health services by discriminatory practices of the staff and the uncertain and often excessive costs of nominally 'free' services. Private maternity clinics, however, offer only a few antenatal or preventative services, and are costly. The inappropriate use of injections of synthetic oxytocin for labour augmentation (administered by untrained practitioners, after inadequate assessments, in the labouring woman's home, and without monitoring) has risen from 13% to 50% of deliveries. Hospital deliveries have risen from about 1% to 10%, almost all unplanned, and often bankrupting poor families. Neo-natal mortality rates increased, child (under-5) deaths declined but gender differentials in mortality increased. In the Hindu village, the sex ratio at birth rose from 1293 to 1412 males per 1000 females, whereas in the Muslim village it declined from 1036 to 940. Interviews with doctors running ultra-sound clinics reinforced our understandings of the social distribution of sex preferences and female foeticide.

General marital fertility rate (GMFR) presents the number of children born in a year per thousand married women in the age group 15-49. The total marital fertility rate (TMFR) presents the total number of children expected to be born to a married woman during her whole reproductive period starting at age

15 and ending at around 50 years. The child mortality rate presents number of children who are born alive but dying before their second birthday per thousand live born children (sheriff, Abusuleh, 1995, p-2951).

A combination of a positive growth of population and a low infant mortality rate (also low death rate) might have enabled a growth rate of population as a whole. Nevertheless, one wonders as to what could be the possible reasons for low child mortality among Muslims while the fertility rates are supposedly higher, and that they are also socio-economically worse-off.

The level of fertility as measured by GMFR and TMFR were higher for Muslims in both rural and urban areas. But the child mortality among both the urban and rural Muslims is comparatively low. More recently, however there had been a noteworthy increase in the acceptance of family planning methods among the Muslims. In fact the percentage change in the family planning use is marginally higher than for the Hindus. The inter-personal communication regarding the family planning use has also increased substantially among the Muslims in India (sheriff, Abusuleh, 1995, pp.2951-2953).

India is considered an overpopulated country and India's population policy seeks to achieve replacement level fertility by 2010. However, population policy implementation in India has come under severe attack, more so due to the element of coercion inherent in the promotion and acceptance of modern contraceptives. Besides, Indian population policy does not adequately recognize the multi-dimensionality of the economic and social forces that prevail upon the household decisions regarding the size of families. The population programme is over dependent on female sterilization with little or no choice based access to a basket of family limitation procedures. There is little recognition of the fact that ultimately it is development and equity that empowers citizens to make informed choices with respect to family formation. In this regard the impact of education, especially of women, has shown dominant influence, not only in reducing fertility but also in the reduction of infant and child mortality,

improvement in birth weights and overall human development (Sachar Committee, p-27). Safe motherhood means ensuring that all women receive the care that they need to be safe and healthy through pregnancy and childbirth. It is estimated that at least 1,600 women die every day from complications related to pregnancy and childbirth. Complications of pregnancy and childbirth are the leading cause of death and disability for women (aged 15 to 49 years) in developing countries [World Development Report 1993]. Over one-fourth of deaths of women in reproductive age in many developing countries are related to pregnancy.

Maternal mortality is just the tip of the iceberg of the health problems women face. Many women do not die of causes related to pregnancy but suffer severe morbidities. Due to miscarriage, induced abortion, and other factors, about 40 percent of the pregnancies in developing countries result in complications, illness or permanent disability for the mother or child (WHO 1992a).. Another study indicates that in developing countries, for each maternal death, a further 10-15 woman suffer from serious impairments (Padma. G, Rama 2005, p -465).

Every time a woman is pregnant, she risks a sudden and unpredictable complication that could result in her death or injury. At least 40 per cent of all pregnant women will experience some type of complication during their pregnancies. The main purpose of antenatal care is for early detection of some complications or risk factors. Antenatal care refers to the pregnancy related care provided by a health worker in a medical facility or at home.

Government of India has proposed a minimum of three antenatal visits during a pregnancy. This includes at least three antenatal care visits, iron prophylaxis supplementation, and two doses of tetanus toxoid vaccination, detection and treatment of anaemia in mothers, high blood pressure check-ups and management of high-risk pregnancies. Commonly used factors to identify risk are height, weight, age, parity and previous history. Other factors such as antenatal bleeding, sexually transmitted diseases, and transverse presentation are also identified as risk factors.

Everyone expects a woman to bear a child within a year or two after marriage in most communities. Culturally, pregnancy is highly valued. First pregnancy is revered in families. Women perceive that there is an elevation in their 'status' within the family once they are pregnant. Being pregnant is a moment of joy and proud for husband and parents. Also a few women, especially from scheduled castes and backward castes, mentioned that if one is not pregnant till two years after her marriage, she is subject to criticism. Therefore many preferred to conceive at earliest after the marriage (p-468).

All women have a favourable attitude towards family planning methods. They feel that if not for the availability of these methods, a woman would continue to bear children all through the reproductive age. Though women are in favour of limiting the size of the family, yet many are not in favour of using a method before first conception or between pregnancies due to the fears of not conceiving when desired. Women are also worried about the health problems associated with usage of temporary methods. Some young women belong to upper castes and backward castes from both the districts, however, wish to postpone first pregnancy. Though they have no adequate knowledge about health consequences related to teenage pregnancy, their main concern is not to get involved into the responsibilities of motherhood soon after marriage. In such cases women feel that husbands' cooperation is very much needed. Otherwise, they feel it is embarrassing for them to go to a shop to buy or get from the health centre. However in the villages where ANM regularly visit, some women request them for contraceptive pills.

Women's knowledge is very poor about the problems, which may lead to risks in pregnancy. Only a few of them feel that 'high blood pressure', 'convulsions', 'vaginal bleeding' could be serious. Knowledge about problems during delivery is very poor. Most of the women believe that it is better for a woman to have menstrual bleeding for a month after delivery.

Many women feel that men do not accompany women to a doctor or health centre during pregnancy, delivery or after delivery. Most of the elderly participants said that it is not nice to expect men to leave their work and go with wife to a doctor. These women opine that it is not an area for men to get involved. At the same time all women feel that men never understand what a woman undergoes during pregnancy and after childbirth.(para-25, pp-470)

Not everyone agrees, however, that encouraging men's participation in reproductive health activities is a good way to improve women's reproductive health. By and large men the main decision-makers of a household, therefore in this particular context an attempt has been made to understand men's knowledge levels and their perceived role towards safe motherhood.

Maternal care includes not only care during pregnancy and delivery but also during post-partum period. Care after delivery is highly neglected by both women as well as health care providers. The health workers in rural areas appear to be burdened with multiple tasks. Thus, they divert their efforts more towards immunization programmes and meeting the sterilization targets rather than on post-partum care. Women's knowledge levels are also very poor with respect to delivery and post-partum care. They wrongly perceive that many problems could occur only during pregnancy rather than during delivery or post-partum period (Padma. G, Rama 2005, pp.470-473).

India has made considerable progress in social and economic development in recent decades, as improvements in indicators such as life expectancy, infant mortality, and literacy demonstrate. However, improvements in women's health, particularly in north, have lagged behind gains in other areas. India is one of the few countries where males significantly outnumber females, and its maternal mortality rates in rural areas are among the world's highest, Infectious diseases, malnutrition, and maternal and prenatal causes account for most of the disease burden. Females experience more episodes of illness than males are more likely to receive medical treatment before the illness is

advanced. Because the nutritional status of women and girls is compromised by unequal access to food, by heavy work demands, and by special nutritional needs (such as for iron), females are particularly anemia. Women, especially poor woman, are often trapped in a cycle of ill health exacerbated by child bearing and hard physical labor. (Article no.18/ THE HINDU, APRIL 2,2001 pp-5).

The HIV/AIDS in epidemic in India are spreading rapidly and increasing will affect women's health in coming years. A study estimated that between 2-5 million Indians are currently infected with HIV (AIDS control and prevention project of family health international et-al, 1996). The incidence of AIDS is spreading from high risk population to the general population, and the infection has spread even to new born babies.

The highest rates of infection are found in population groups with certain high risk behaviour (i.e., sex workers, and sexually transmitted disease patients). However, infection also is increasing in the general population. For example, HIV prevalence among pregnant women in the state of Tamil Nadu quadrupled between 1989 and 1991 from 0.2 to 0.8% (U.S. Bureau of the census, 1995). The epidemic is fueled by both married and unmarried men visiting sex workers who have high rates of infection. Women in India have very little knowledge of AIDs. The NFHS found that a large majority of Indian women had never heard of AIDS. (U.S. Bureau of the Census, (1995).

Dharmalingam and Morgan (2005), suggest an alternative or complementary dynamic that stresses intergroup dynamics and the role of family and demographic behavour as markers of group identity sources of solidarity. The pervasive religious tension in Indian political discourse and the currency of demographic arguments increase the plausibility of this argument. Moreover, Islam's opposition to specific contraceptive methods may limit their use among Muslims especially if the family planning programmes push terminal and the government is Hindu controlled.

The position of women and women's roles in reproduction occupies central positions in religious, popular, and political discourse. It may be conjectured that the Muslim community response to these concerns, especially when they are a minority, is a stronger emphasis on aspects of family life conducive to childbearing or opposition to particular forms of birth control, for example sterilization. Larger family sizes, greater demand for children, and higher risks of unwanted pregnancies could be the unintended outcomes of these group struggles (Dharmaligam and morgan,2005, pp 430-431).

Health is an indicator of well being that has direct implications not only for the quality of life but also indirect implications for the production of economic goods and services. 'Health for all by the year 2000' was a national goal set by Indian policy makers over 20 years ago Alma Ata. Since then a lot of planning, effort and public expenditure have gone into improving human health both in rural and urban India. In India, there Is a high incidence of communicable diseases normally associated with low levels of sanitation and public hygiene, poor quality of drinking water and under-nutrition.

It is clear that to objectively evaluate the disease burden of a country and its many regions, community level estimates of morbidity are essential. DALY is 'a measure which combines healthy life years lost of because of premature mortality with those lost as a result of disability'. There are two separate prevalence rates, Short Duration Morbidity Prevalence Rate (MPR-SD), and Point Prevalence Rate of Major Morbidity (PPR-MM). Under MPR-SD, information was collected on different types of diarrhoea, respiratory infections, fevers and other episodes of acute illness. Direct enquiries were made to find out the PPR-MM of eight clearly identifiable diseases, namely epilepsy, hypertension, diabetes mellitus, heart disease, mental illness, tuberculosis, leprosy, and cancer.

Short Duration Morbidity Prevalence Rate (MPR-SD)

According to IndiaHuman Development Report (1999) incidences of diarrhoea, cough and unspecified fevers during a 30-day reference period preceding the date of survey were considered as constituting short duration morbidity. The MPR-SD for all India worked out to 122 per 1000 population for the 30-day reference period. Females reported slightly higher MPRs (127) than males (117) and the gender disparity worked out to 1, 08. The annual MPR-SD which can be computed by multiplying monthly MPR-SD by 12, worked out to 1464 per 1000 population. The female morbidity is very high in comparison to male morbidity. The incidence of diarrhoea was generally low among females but the prevalence of cold and cough, and especially fevers is high among women. Gender disparity in short duration morbidity is very high among the 15-34 years age group in comparison with the 35-59 and 60 and over age groups. It is likely that such morbidity is related to pregnancy and childbirth related problems.

Point Prevalence Rate of Major Morbidity (PPR-MM)

An attempt was made to establish if any of the family members in a household were on medication for chronic or major illnesses such as epilepsy, heart disease, hypertension, tuberculosis, diabetes, mental disorders, and leprosy at the time of the survey. Such an investigation enables estimation of the all India Point Prevalence Rate (PPR) for all ages and all types of major morbidity and worked out to 4,578 per lakh population.

There are a number of inter-state variations in PPRs. The general pattern is that PPRs are higher in the southern states and in Uttar Pradesh, Bihar, and Rajasthan. The prevalence rate increases with household income, and this increase is specially marked in cases of hypertension and diabetes. However, the prevalence of tuberculosis, leprosy and cancer falls as household income increases. The prevalence of hypertension and heart disease has been reported to be high for the rich class people. The MPR of major illnesses is highest among the Christians (the most literate group) with evidence of a high incidence of

hypertension- about twice the national average – as also of diabetes and mental disorders. The prevalence of tuberculosis was high among STs and SCs, might be related to their low levels of living consequent malnutrition. Point prevalence of tuberculosis decreases substantially with a rise in household income but practically all the difference is due to the differential incidence among males. The incidence among women across household income classes remains unchanged. This pattern of gender differentials with regard to the incidence of tuberculosis is similar across other population group classifications as well. The prevalence of tuberculosis is higher among villages categorized as relatively less developed (India Human Development Report,1999, pp.132-146).

In view of the slow progress in health and demographic indicators during the 1990s, the Government of India has initiated several new population and health measures to remove impediments and to promote more broad-based success of health and population stabilization programmes (NFHS-3).

The provision of contracaptive information is fundamental to the ability of women and men (including adolescents) to make informed choices about reproductive health decisions. In NFHS-3, women and men were asked about their knowledge of each of 10 methods of contraception. Information on knowledge of contraception was collected in two ways. First respondents were asked to spontaneously mention all the methods of contraception that they had heard of. For methods not mentioned spontaneously, the interviewer described the method and probed for whether the recognized it.(NFHS-3).

There are 14 million Indians suffering with TB with 2.5 million infectious and 5 lakh deaths taking place annually. More women die of TB than due to pregnancy and childbirth related causes. Women suffering from genitor- urinary TB presenting with infertility neither get diagnosed nor treated appropriately. Even as women care for their men folk, in laws and children, women with TB do not get similar care and worse so, are often deserted or sent back to their parental home, due to stigma of TB and the added oppression, humiliation

related with infertility associated with genitor-urinary TB. Women suffer much more firstly from the illness of a family member specially children and so also from their own illness as they try to cope with house work and illness.

A woman may become pregnant by failure of contraceptive method. Women who have become pregnant because of no use of any contraceptives, unmarried women or widow or victim of rape who became pregnant can terminate their pregnancy legally, under safe clean condition by qualified doctors. Eleven percent of maternal deaths are due to unsafe and septic abortion (Mudunuri, lakshmipathi, Raju, (2007). pp 125-128).

Table- 3.1 Birth Order according to religious characteristics

Percent distribution of births during the three years preceding the survey by birth order, according to religious characteristics India,2005-06, and percent distribution of birth to ever-married women by birth order, NFHS-3, NFHS-2,and NFHS-1

	Birth Order					
Religious Characteristics	1	2	3	4 +	Total	Number of births
Religion						
Hindu	32.0	27.7	15.9	24.4	100.0	24,147
Muslim	25.2	25.7	16.8	32.4	100.0	4,324
Christian	32.3	32.9	15.9	18.8	100.0	611
Sikh	37.7	34.0	18.3	10.1	100.0	351
Buddhist/Neo-Buddhist	32.5	41.7	13.0	12.8	100.0	161
Jain	43.2	38.2	18.1	0.5	100.0	58
Other	32.3	27.6	15.9	24.2	100.0	3,456
Births to ever-married women						
NFHS-3	31.2	27.7	16.0	25.1	100.0	33,104
NFHS-2	29.0	25.8	17.7	27.5	100.0	32,496
NFHS-1	27.6	23.9	17.6	30.9	100.0	37,916

Source: NFHS-3 (2005-06), pp.87, table.4.6

Table-3.1 reveals that distribution of births during the three year period before the survey by birth order for religious characteristics. Overall, as expected, the proportion of births at each order is larger than the proportion at the next higher order. The proportion births of order four or higher is particularly high for births to women with Muslim women (32 percent) as compared to other religious group that is Hindu (24.4 percent), Christian (18.8 percent) and so on.

The decrease in fertility over time is evident from a comparison of the birth order distribution in NFHS-1, NFHS-3 and NFHS-3 for ever-married women. The proportion of births of orders four or higher decreased from 31 percent in NFHS-1 to 28 percent in NFHS-2 and 25 percent in NFHS-3.

Table 3. 2 Knowledge of contraceptive methods among adolescents

Percentage of women age 15-24 who knows at least one contraceptive method and who know at least one modern method by religious characteristics, India, 2005-06				
		Women		
Religious Characteristic	**Know any method**	**Know any modern method**	**Know any modern temporary method**	**Number of Women**
Hindu	96.5	96.5	87.9	37,705
Muslim	94.4	94.2	87.0	7,307
Christian	92.5	91.8	82.2	1,043
Sikh	93.4	93.3	90.2	789
Buddhist/Neo Buddhist	98.1	98.1	89.2	380
Jain	97.3	97.3	92.3	133
Other	82.8	82.2	66.2	197

Note: female sterilization, pill, IUD, female condom, emergency contraception, and other modern methods

Source: NFHS-3 , pp-115, Table- 5.2

Table -3.2 shows the extent knowledge of any method, any modern method, and any modern temporary method of contraception among adolescent women (age 15-24) by religious characteristics. Ninety-four percent of adolescent Muslim women know any contraceptive method and any modern method. However, only 87 percent reported knowledge of any spacing method.

Table- 3.3 Current use of Contraception by Social Groups

Particular	Women belonging to different social groups						
	Hindu	Muslims	Christian	Sikh	Jain	Buddhist	Others
Any Method	57.8	45.7	57.6	66.5	75.4	67.7	25.3
Any Modern Method	50.2	36.4	48.9	58.4	69.1	64.7	21.1
Pill	2.7	5.7	1.4	2.6	1.6	1.6	4.0
IUD	1.6	1.8	2.4	7.9	6.0	0.7	0.6
Condom	4.8	6.8	3.6	15.8	19.7	3.7	1.8
Female Sterilization	39.9	21.3	40.7	31.4	41.1	54.1	14.2
Male Sterilization	1.1	0.6	0.7	0.8	0.7	4.5	0.4
Any Traditional Method	7.6	9.3	8.8	8.1	6.3	3.0	4.1
Rhythm	4.9	5.6	5.4	4.8	2.6	2.6	1.5
With-drawal	2.4	3.4	3.4	3.3	3.3	0.4	1.8
Folk Method	0.4	0.3	0.1	0.0	0.5	0.0	0.8
Not currently using	42.2	54.3	42.4	33.5	24.6	32.3	74.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of Women	75,799	12,288	2,041	1,567	279	684	333

Source: NFHS-3, p-122, Table-5.6.1

Table -3.3 shows the differentials in contraceptive use among currently married women age 15-49 by the religion. There are marked differences in the use of different contraceptive methods among currently married women. Current use of IUDs, condoms, the rhythm method, and withdrawal generally increases and

current use of female sterilization generally decreases with an increase in the educational level of women. The contraceptive prevalence rate is 46 percent among Muslims women and 58 percent each among Hindu and Christian women. The highest contraceptive prevalence rate is among Jains 75 percent, followed by Buddhists/Neo-Buddhists 68 percent and Sikhs 67 percent. The other religion is recorded the lowest contraceptive prevalence. Among the specific religious groups, the prevalence of female sterilization is highest among Buddhist/Neo-Buddhists (54 percent) and lowest among Muslims (21 percent). The use of pills, IUDs, and condom is highest among Jains (27 percent), Sikhs(26 percent) and Muslims (14 percent). Use of traditional methods is highest among Muslims and Christian women (9 percent).

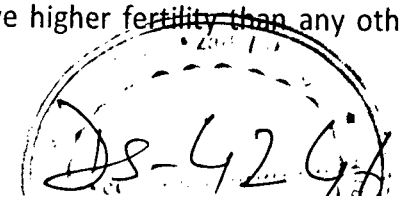
Table-3.4 Total Fertility Rate by Religious Characteristics

Total fertility rate for the three years preceding the survey, percentage of women age 15-49 currently pregnant, and mean number of children ever born to women age 40-49 by religious characteristics India, 2005-06

Religious characteristics	Total fertility rate	Percentage currently pregnant	Mean number of children ever born to women age 40-49 years
Hindu	2.65	5.0	3.97
Muslim	3.09	6.7	4.60
Christian	2.35	3.8	3.27
Sikh	1.96	3.6	3.56
Buddhist	1.96	4.9	3.82
Jain	2.02	6.4	3.27
Other	2.65	4.9	3.87

Source: NFHS-3, 2005-06, p-80, Table 4.2

Table-3.4 shows variation in the total fertility rate, the percentage of women currently pregnant, and the mean number of children ever born to women age 40-49 by the religion. The TFR is almost half a child higher for Muslims than for Hindus, and both of these groups have higher fertility than any other religious



group. The percentage of women currently pregnant is higher among Muslims and Jains (7 and 6 percent) than the other religion. The mean number of children ever born to women age 40-49 years is highest among Muslims (5 percent) in comparison to Hindus and other religion i.e., Sikhs, Christians, Jains etc. which are almost equally.

Table-3.5 Teenage Pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their child, and percentage who have begun childbearing by religious characteristics, India, 2005-06

	Percentage who:			
Religious Characteristics	**Have had a live birth**	**Are with first child**	**Percentage begun childbearing**	**Number of Women**
Hindu	12.4	3.8	16.3	17,995
Muslim	11.8	5.1	17.0	3,153
Christian	5.9	2.0	7.8	462
Sikh	3.5	2.2	5.7	289
Buddhist	7.6	3.0	10.6	181
Jain	4.7	8.3	13.1	42
Other	12.2	3.4	15.6	2,686

Source: NFHS-3, 2005-06,p.94, Table. 4.11

Table 3.5 shows the proportion of women age 15-19 who have had a live birth and women age 15-19 currently pregnant with their first child by religious characteristics. The third column provides the percentage of women who have begun childbearing, which is the sum of the previous two percentages. The 12 percent of Muslim women age 15-19 have become mothers and 5 percent of Muslim women age 15-19 are currently pregnant with their first child. This means that one in six Muslim women age 15-19 have begun childbearing. The percentage of women who have begun childbearing increases sharply with age, from 3 percent at age 15 to 36 percent at 19. The level of teenage motherhood and pregnancy is higher for Hindu and Muslim women age15-19 (16-17 percent) than for Jains (13 percent), Christians (8 percent), and Sikhs (6 percent).

Table-3.6 Contraception Prevalence Rates for Ever Married Women (EMW) by Social Groups

Social Groups	Termination Method		Spacing Method		% EMW
	%EMW Users	Vasectomy % to All	%EMW Users	Loop/Cop T % to All	Using Methods
Caste					
STs	29.5	13.5	4.4	35.5	33.9
SCs	26.7	9.6	4.7	19.1	31.4
Religion					
Hindus	31.4	8.2	4.9	29.2	36.3
Muslims	16.5	7.4	8.2	18.7	24.7
Christians	35.1	11.1	13.0	33.3	48.1
Other Minorities	32.7	12.6	13.7	38.9	46.5

Source: India: Human Development Report, 1999.

Table 3.6 shows the Contraceptive Prevalence Rate (CPR) for ever married women by social groups. The termination method and spacing method is higher among STs than the SCs. As far as religious groups are concerned, contraception is practiced least among Muslims (CPR of 25). Among Christians, the CPR is 50 while Hindus have lower CPRs (36).

Table 3.7 examines whether women's use of antenatal, delivery and postnatal care services from health workers varies by level of women's empowerment as measured by the three indicators of empowerment. In societies where health care is widespread, women's empowerment may not affect their access to reproductive health services; in other societies, however, increased empowerment of women is likely to increase their ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood.

The table shows the women's empowerment in terms of decision making is not related to whether women received antenatal care, but access to appropriate delivery assistance and timely postnatal care increases with the number of decisions that women participate in. 52 percent of women who participate in most of the four decisions had a delivery assisted by health personnel and 37 percent received postnatal care from health personnel within the first two days after delivery, compared with 46 percent and 30 percent, respectively, of women who do not participate in any of the four decisions.

The second empowerment indicator is related to all three maternal health indicators: women who reject wife beating are more likely than women who accept one or more reasons for wife beating to receive antenatal care from health personnel, receive delivery assistance from health personnel, and receive postnatal care from health personnel within the first two day after delivery. In each case the differential is about 8-10 percentage points between those who agree with no reason for wife beating and those who agree with all. The third indicator bears an expected U-shaped relationship with all three maternal health indicators. Women who agree with no reason for refusing the husband sex and those who agree with all three reasons are more likely to have received antenatal care from health personnel, received delivery assistance from health personnel, and received postnatal care from health personnel within the first two day after delivery than women who agree 1 or 2 reasons.

Table 3.7 Reproductive health care by women's empowerment

Percentage of women age 15-49 with a live birth in the five years preceding the survey who received antenatal care, delivery assistance and postnatal care from health personnel for the most recent birth, by indicators of women's empowerment, India, 2005-06

Empowerment indicator	Received antenatal care from health personnel	Received delivery assistance from health personnel	Received postnatal care from health personnel within the first two days since delivery	Number of births
Number of decisions in which participate				
0	74.4	46.1	29.7	9,495
1-2	77.6	49.5	34.0	11,324
3-4	76.0	51.9	37.2	18,207
Number of reasons for which wife-beating is justified				
0	79.8	53.6	37.1	17,830
1-2	73.0	48.3	33.0	8,134
3-4	73.4	47.9	33.9	6,948
5-6	72.0	42.7	28.9	3,964
7	71.6	44.0	29.6	2,801
Number of reasons given for refusing to have sexual intercourse with husband				
0	77.8	48.6	35.2	4,139
1-2	72.9	44.6	30.3	7,451
3	76.5	51.3	35.3	28,087
total	**75.9**	**49.8**	**34.4**	**39,677**

Source: NFHS-3, 2005-06, p-490, table. 14.23

Table 3.8 shows how these three indicators relate to each other. The relationship of both decision making and attitudes towards wife beating with the indicator based on women's agreement with a wife's right to refuse her husband sex is particularly weak. The table shows a positive association between women's participation in decision making and women's rejection of wife beating. Forty percent of women who reject wife beating for all reasons (index value is 0)

Table 3.8 Indicators of Women Empowerment

Percentage of women age 15-49 who participate in all decisions making, percentage who disagree with all reasons for justifying wife beating who agree with all reasons for refusing sexual intercourse with husband, by value on each of the indicators of women's empowerment, India, 2005-06

Empowerment indicator	Percentage who participate in all decision making	Number of currently married women	Percentage who disagree with all the reasons justifying wife-beating	Percentage who agree with all the reasons for refusing sexual intercourse with husband	Number of women
Number of decisions in which women participate					
0	na	19,057	40.7	67.4	19,057
1-2	na	24,797	42.1	70.2	24, 797
3-4	na	49,235	46.5	70.5	49,235
Number of reasons for which wife-beating is justified					
0	39.9	41,069	100.0	72.4	56, 685
1-2	34.3	18,847	na	64.4	25, 167
3-4	34.2	16,248	na	60.8	21, 080
5-6	33.0	9,775	na	61.9	12, 695
7	35.3	7,151	na	68.7	8.757
Number of reasons given for refusing to have sexual intercourse with husband					
0	36.6	10,039	46.2	na	**16, 301**
1-2	33.9	18,086	33.5	na	**24, 142**
3	37.5	64,964	48.9	100.0	**83, 942**
Total	**36.7**	**93,089**	**45.6**	**67.5**	**124, 385**

na = not applicable

Source : NHFS-3, pp.487, table 14.21

participate in all four decisions, compared with 34 percent among those agree with one or more reasons (index value 1-7). Also, the percentage of women who disagree with all the reasons for wife beating increases from 41 percent for women who do not participate in any decisions to 47 percent who participate in most of the decisions asked about.

Women's participation in decision making is not strongly related to women's agreement with a wife's right to refuse her husband sex. The percentage of women who participate in all four decisions is only marginally higher among who agree that a wife has the right to refuse her husband sex for all three reasons than among women who agree with none or 1-2 reasons. However, the proportion of women who agree with all three reasons is slightly higher among women who participate in 3-4 decisions (71 percent) than women who participate in none (67 percent). The proportion of women who agree with all three reasons for a wife beating to refuse her husband sex is higher among women who reject wife beating for any reason (72 percent), compared with women who agree with wife beating for one oe more reasons (61-69 percent).

A women's ability to control her fertility and the contraceptive method she chooses are likely to be affected by her status, self image, and sense of empowerment. Women unable to control other aspects of their lives may be less likely to feel they can make and carry out decisions about their fertility. Women may also feel the need to choose methods that are less likely to be evident or which do not depend on their husband's cooperation. The number of decisions in which a woman has the final say is indicative of women's empowerment and reflects the degree of decision- making control women are able to exercise in areas that affects their lives. The indicator 'Number of reason for which wife beating is justified' has an inverse association with a women's greater sense of entitlement, self esteem, and status and therefore her level of empowerment. The indicator 'Number of reasons a wife can refuse to have sex with her husband' reflects perceptions of the sexual roles and of women's rights over their bodies and also indicates women's sense of self and empowerment.

Table-3.9 Current use of Contraception by Women's Status

Percent distribution of currently married women age 15-49 by current contraceptive method, according to selected indicators of women's status India, 2005-06

Empowerment indicators	Any Method	Any modern method	Female sterilization	Male sterilization	Temporary modern female methods	Male condom	Any traditional method	Not currently using	total	Number of women
Number of decisions in which women participate										
0	44.0	37.0	28.1	0.7	4.1	4.0	7.1	56.0	100.0	19,057
1-2	55.3	46.5	34.9	0.8	5.3	5.5	8.8	44.7	100.0	24,797
3-4	61.6	54.1	42.1	1.3	5.1	5.6	7.6	38.4	100.0	49,235
number of reasons for which wife-beating is justified										
0	57.5	48.1	33.6	0.9	6.2	7.3	9.4	42.5	100.0	41,069
1-2	55.6	47.7	37.4	1.0	4.6	4.8	7.9	44.4	100.0	18,847
3-4	54.3	48.2	40.1	1.0	3.9	3.2	6.2	45.7	100.0	16,248
5-6	56.3	50.6	42.7	1.2	3.4	3.2	5.8	43.7	100.0	9,775
7	56.2	51.5	44.4	1.6	3.4	2.1	4.7	43.8	100.0	7,151
Number of reasons given for refusing to have sexual intercourse with husband										
0	56.2	49.9	41.2	1.2	4.4	3.2	6.3	43.8	100.0	10,039
1-2	53.6	46.8	37.7	1.1	4.3	3.7	6.9	46.4	100.0	18,086
3	57.1	48.8	36.6	1.0	5.2	6.0	8.3	42.9	100.0	64,964
Total	**56.3**	**48.5**	**37.3**	**1.0**	**5.0**	**5.2**	**7.8**	**43.7**	**100.0**	**93,089**

Table-3.12 Knowledge of contraceptive methods by Northern India: Women

Source: NFHS-3, pp 489, table 14.22

Table 3.9 shows that any contraceptive use, modern contraceptive use, and the use of the different modern methods and traditional methods are generally higher the greater the number of decisions in which women participate. In particular, 37 percent of women who participate in no decisions are currently using a modern contraceptive method, compared with 54 percent of women who participate in 3-4 decisions. The association of contraceptive use with the two attitude-based empowerment indices is more complex. Modern method use is only slightly higher among women who agree with all reasons for wife beating than it is for women who do not agree with any reason; however, this relationship is largely affected by the fact that a much lower proportion of women who do not agree with wife beating are sterilized (34 percent),compared with women who do agree with wife beating for one or more reasons (37-44 percent). Temporary modern female method use, condom use, and traditional method use, however, are all strongly and positively associated with women's rejection of wife beating. Condom use for example among women who reject wife beating (index value 0), at 7 percent, is more than three times as high as among women who agree with all reasons (index value 7). A similar relationship exists between the third empowerment index and the different contraceptive methods. Female sterilization use declines as the index value increases, but temporary female method use and traditional method use increase as the index value increases. Thus, the participation in decision making is positively associated with the use of contraception and that having more gender egalitarian attitudes is positively associated with temporary method use

Table -3.10 Fertility Rates by Religious Groups in Rural India

Religious groups	CBR per 1000	TFR(15-49)	Ave. Children Even Born to Ever Married Women		
			Boys	Girls	Total
Hindus	32	4.2	1.5	1.3	2.8
Muslims	39	5.8	1.8	1.5	3.4
Christians	20	2.1	1.2	1.1	2.4
Other minorities	28	3.9	1.6	1.4	3.0

Source: Indian Human Development Report.(1999), pp.156, table- 8.2

Table 3.10 reveals the CBR per 1000, TFR age group 15-49 and Average Children Ever Born to Ever Married Women (Boys and Girls) by the religion. The Muslims have a highest CBR in comparison to other religious groups i.e., Hindus and Christian. The Muslims have a CBR of 39, Hindus a low 32, whereas the Christians it is 20 per thousand population. A high CBR may be associated with low levels of living and low level of literacy among these religious groups. Like the CBR, the TFR is also high among Muslims (5.8) than Hindus (4.2) and Christian (2.1).

Table 3.11 shows the proportion of women age 15-19 who have had a live birth or who are currently pregnant with their first child by northern state. The proportion of women age 15-19 who have begun childbearing is highest in Rajasthan (16 percent), Uttar Pradesh (14 percent) and the level of childbearing is lowest (less than 5 percent) in Himachal Pradesh and Jammu and Kashmir.

Table-3.11 Teenage pregnancy and motherhood by Northern India

North India	Percentage who :		
	Have had a live birth	Are pregnant with first Child	Percentage who have begun childbearing
India	12.1	3.9	16.0
Delhi	3.8	1.2	5.0
Haryana	7.5	4.6	12.1
Himachal Pradesh	2.1	0.9	3.1
Jammu & Kashmir	3.4	0.8	4.2
Punjab	3.6	1.9	5.5
Rajasthan	12.6	3.4	16.0
Uttaranchal	3.6	2.6	6.2
Uttar Pradesh	11.2	3.1	14.3

Source: NFHS, 2005- 06, pp-95, table 4.12

Table 3.12 reveals the knowledge of different methods of contraception by northern India. Knowledge of every contraceptive method increased substantially between NFHS-1 and NFHS-2, with particularly rapid increases for the modern spacing methods. The rise in knowledge continued between NFHS-2 and NFHS-3 (for every method except male sterilization), but the pace of change was more gradual. Knowledge of any contraceptive method and female sterilization was almost universal in all three NFHS surveys. The proportion of currently married women who know about male sterilization decreased from 89 percent in NFHS-2 to 83 percent in NFHS-3 and the present level of awareness is slightly lower than in NFHS-1 (84 percent). The knowledge of any modern method among currently married women is almost universal (94 percent) in northern India. Female sterilization is the most widely known method at least 90 percent of women knows in northern India. The awareness of family planning methods, especially of spacing methods, varies widely across the states. In Delhi, Haryana, Punjab, and Uttar Pradesh, the level of awareness of each of the three spacing methods (pill, IUD and condom) exceeds 80 percent. In most states, awareness about the newly marketed methods (female condoms and emergency

Table-3.12 Knowledge of contraceptive methods by Northern India: Women

Percentage of currently married women who know any contraceptive method by specific method, according to Northern India, 2005-06, and NFHS-2 and NFHS-1

State	Any method	Any Modern method	Female Sterile-zation	Male Sterile-zation	Pill	IUD	Inject-ables	Condom/ Nirodh	Female condom	Emer-gency contra-ceptive	Other Modern method
India	99.3	99.2	98.4	83.2	87.2	74.3	52.6	76.1	8.3	11.9	0.1
NFHS-2	99.0	98.9	98.2	89.3	79.5	70.6	u	71.0	u	u	U
NFHS-1	95.8	95.5	94.6	84.5	66.2	60.8	19.3	58.1	u	u	u
Delhi	100.0	100.0	99.9	98.5	99.4	96.6	81.2	98.0	28.0	32.1	0.3
Haryana	99.0	98.9	96.2	82.4	90.2	84.5	46.1	85.4	4.9	12.8	0.2
Himachal Pradesh	98.9	98.9	96.6	84.4	83.7	70.0	35.2	82.8	14.5	12.4	0.0
Jammu & Kashmir	98.3	98.3	96.4	84.9	88.6	79.7	63.2	72.2	7.1	8.8	0.2
Punjab	98.9	98.8	96.3	81.3	92.0	88.5	43.1	89.7	12.8	13.6	0.1
Rajasthan	99.7	99.6	99.4	88.3	88.6	73.2	48.6	76.8	4.2	13.1	0.1
Uttaranchal	98.6	98.5	95.3	88.2	93.3	79.9	39.1	87.5	6.6	15.7	0.2
Uttar Pradesh	99.5	99.5	98.9	91.2	95.1	88.0	80.7	93.5	3.2	9.2	0.4

U= Not available

Source: NFHS-3(2005-06),pp-117, table-5.3.1

contraceptives) is quite scant, although emergency contraceptives are more likely to be known than female condoms. The awareness of Female condom and Emergency contraceptive are higher in Delhi (28 and 32 percent).

A perusal of table no. 3.13 of the Prevalence rate (per thousand populations) of Short Duration Morbidity by North India shows that among the Muslims, the highest rate is found to be 439 (Person) and 1.19 (Gender disparity) in Himachal Pradesh. This rate is much higher than the all India rate of 106 (Person) with 1.02 (Gender disparity). Thus, we can say that short duration morbidity is highly prevalent in Himachal Pradesh among the Muslims, while the lowest short term duration morbidity rate is found in Rajasthan with a rate of 73 (Person) and 1.00 (Gender disparity).

Table 3.13 Prevalence Rate (Per Thousand Populations) of Short Duration Morbidity by North India

	Social Groups			
States	**STs and SCs**	**Hindus**	**Muslims**	**Other Minorities**
Haryana				
Person	157	150	161	259
Gender disparity	1.31	1.19	1.35	1.25
Himachal Pradesh				
Person	326	309	439	291
Gender disparity	1.33	1.26	1.19	0.58
Punjab				
Person	125	131	222	161
Gender disparity	1.22	1.16	1.77	1.15
Rajasthan				
Person	108	115	73	38
Gender disparity	0.94	0.94	1.00	-
Uttar Pradesh				
Person	107	96	101	120
Gender disparity	0.90	1.00	1.15	1.58
All India				
Person	126	123	106	137
Gender disparity	1.06	1.08	1.02	1.21
C.V. Person	49.9	51.8	70.7	72.8

Source: India Human Development Report 1999, pp-302

Table 3.14 Prevalence Rate (Per Lakh Population) of Major Morbidity by North India

States	Social Groups			
	STs and SCs	Hindus	Muslims	Other Minorities
Haryana				
Person	7,242	6,183	6,215	3,367
Gender disparity	1.10	1.19	1.34	4.81
Himachal Pradesh				
Person	10,521	10,985	11,298	13,718
Gender disparity	1.28	1.28	0,96	0.87
Punjab				
Person	6,105	4,823	5,303	7,432
Gender disparity	0.60	1.21	1.75	1.24
Rajasthan				
Person	3,303	3,162	2,692	5,909
Gender disparity	1.25	1.09	1.69	0.46
Uttar Pradesh				
Person	3,284	3,415	4,297	3,179
Gender disparity	1.39	1.21	1.22	1.40
All India				
Person	4,147	4,503	4,441	6,171
Gender disparity	1.02	0.99	1.01	1.13
C.V. Person	48.1	48.9	52.0	55.2

Source: India Human Development Report 1999, pp-302

A clear examination of the table no. 3.14 shows that among Muslims, the highest prevalence rate (per lakh population) of major morbidity by North India, is 11,298 (person) in Himachal Pradesh and gender disparity at 0.96, while it is 4,441 (person) and 1.01 (gender disparity), for all India rate. Here, we can see a vast difference in the prevalence rate between Himachal Pradesh and all India rate. The lowest prevalence rate is seen in Rajasthan with a rate of 2,692 (person) and 1.69 (gender disparity). As compared to Rajasthan, the prevalence rate of major morbidity by North India among Muslims is very much higher in Himachal Pradesh.

Table-3.15 Percentage of Ever Married Women Using Termination Methods by Northern States

States	Social Groups			
	STs and SCs	Hindus	Muslims	Other Minorities
Haryana	34.0	38.1	3.8	37.3
Himachal Pradesh	53.2	50.4	47.8	64.6
Punjab	29.9	29.1	43.2	30.1
Uttar Pradesh	12.2	14.9	4.9	10.0
Rajasthan	15.1	25.2	11.2	0.0
All India	27.6	31.4	16.5	33.8

Source: Indian Human Development,1999, pp-335

Table 3.15 shows the percentage of ever married women using termination methods by Northern States among the Muslims. The highest percentage of 47.8 percent is found in Himachal Pradesh, which also showed a big difference when compared with the all India percentage of 16.5 percent. The second highest percentage of 43.2 percent is recorded in Punjab. So, we can say that there is awareness about various termination methods among ever married Muslim women in Himachal Pradesh and Punjab while the awareness level in Haryana is too low with 3.8 percent only.

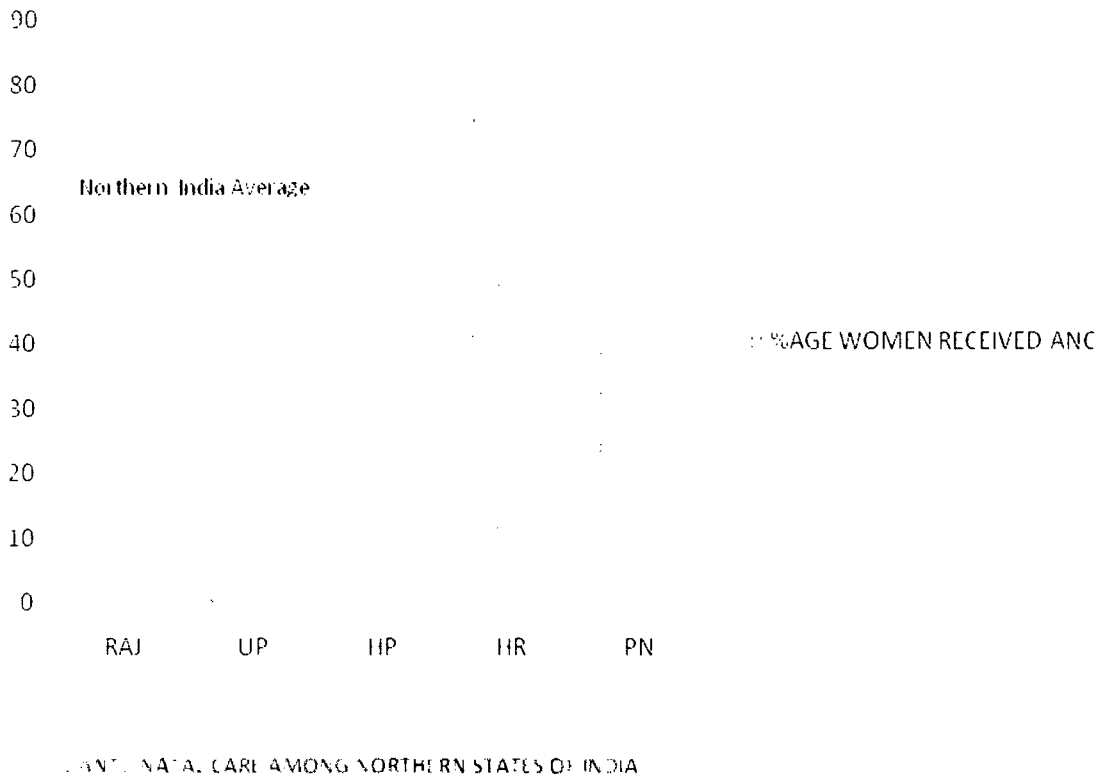
Table-3.16 Percentage of Ever Married Women Using Spacing Methods by Northern States

States	Social Groups			
	STs and SCs	Hindus	Muslims	Others Minorities
Haryana	4.9	6.4	7.4	25.5
Himachal Pradesh	4.0	5.3	3.0	19.4
Punjab	5.0	9.1	12.7	17.7
Uttar Pradesh	8.4	8.2	11.6	25.7
Rajasthan	1.2	1.9	2.1	17.2
All India	4.6	4.9	8.2	13.4

Source: Indian Human Development,1999, pp-336

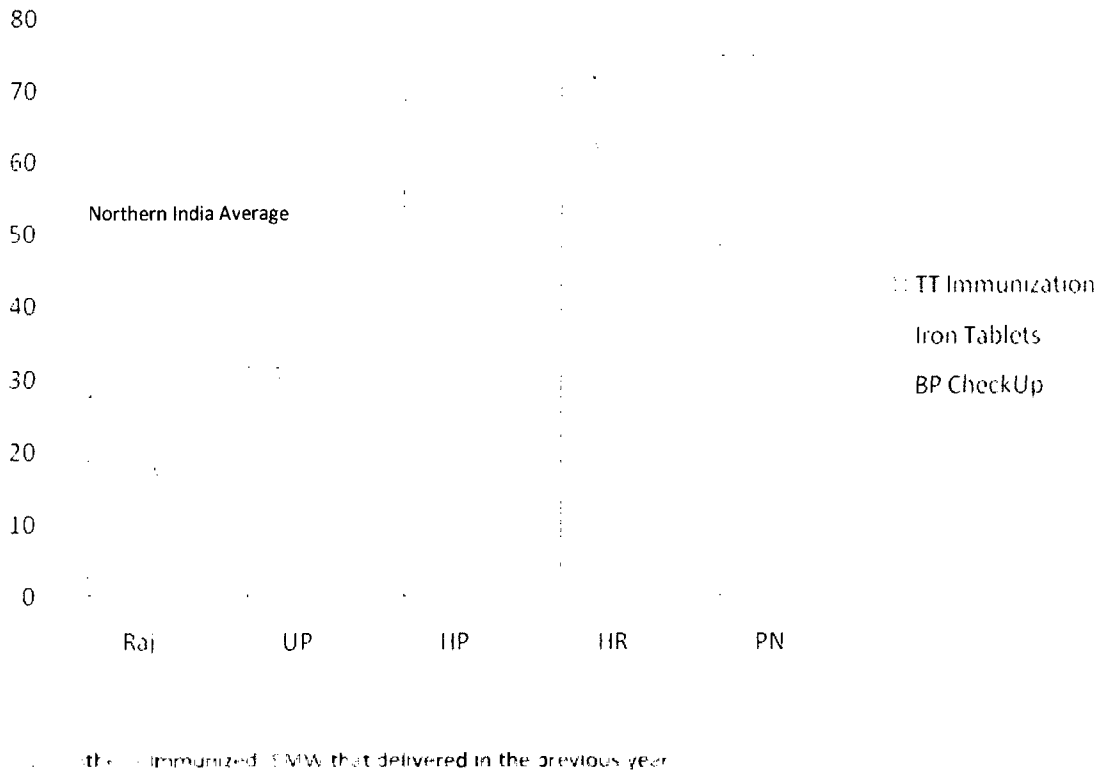
An analysis of table no. 3.16 of the percentage of ever married women using spacing methods by northern states among Muslims shows a highest percentage of 12.7 percent in Punjab and 11.6 percent, the second highest recorded in Uttar Pradesh whereas the lowest percentage is found in Rajasthan (2.1 percent). From the above table no. 16, it can be concluded that the use of spacing methods by northern states among ever married Muslim women is somewhat low and two reasons may be put forward for this-

1. Lack of awareness about various available spacing methods
2. Possible side effects.



ANTE NATAL CARE AMONG NORTHERN STATES OF INDIA

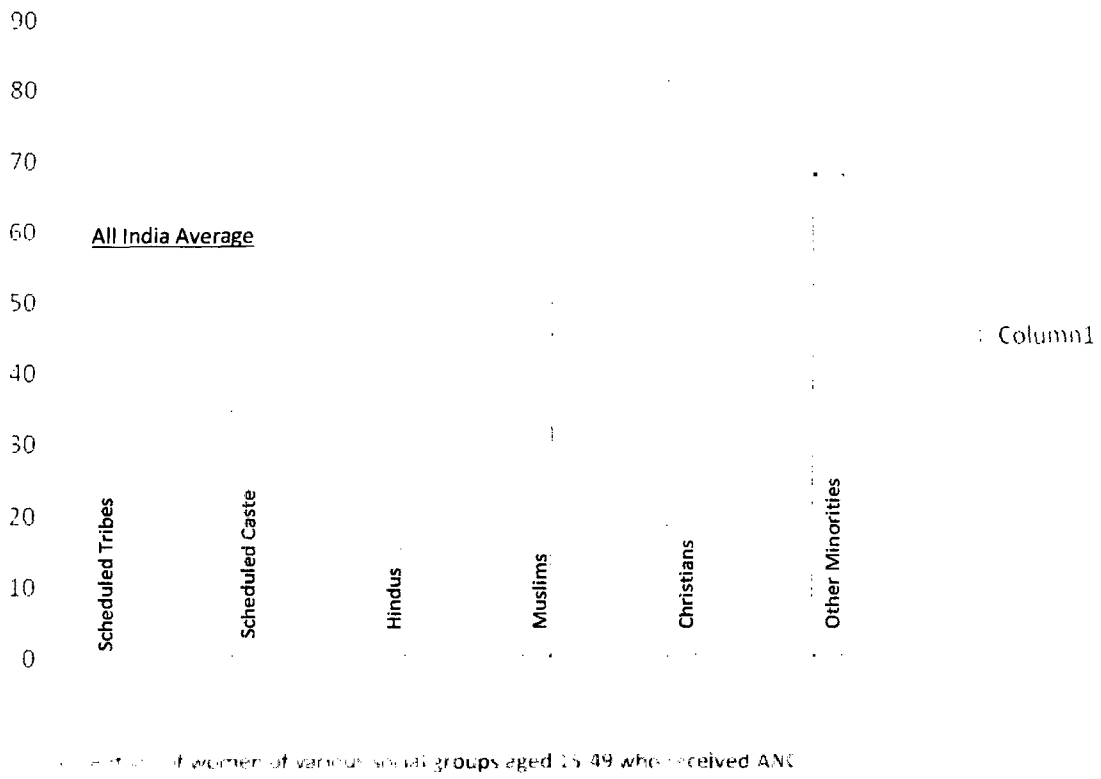
A perusal of the above diagram on ante-natal care among northern states of India reveals that about 80 percent of women in Punjab received ANC which is the highest recorded in India while Rajasthan is at a lowest of 30 percent only. Haryana is at the second highest with an average percentage of 75 percent women who received ANC, the women of Himachal Pradesh stand at third highest (nearly 69 percent), and about 40 percent of women in U.P. received ANC. It can be said that women of Punjab, Haryana and Himachal Pradesh are health conscious as good number of them for ante-natal care.



th[illegible] immunized [illegible] that delivered in the previous year

The diagram above reveals that women in Punjab are at the top for TT Immunization nearly 75 percent of them, more than 40 percent of them takes Iron tablets and an average of 40 percent women go for BP check-up. Rajasthan records the lowest TT immunization (nearly 28 percent) and iron tablets consumption by women is about 18 percent and BP check-up (17 percent). Women in the state of Haryana are the second highly immunized for TT (72 percent) and they are the largest iron tablets consumers more than 60 percent of them while only 20 percent of them go for BP check-up. Women in Himachal Pradesh stand third in TT immunization (69 percent), second highest iron tablet consumption (60 percent) and 18 percent go for BP check-up. In the state of U.P. women stand fourth i.e., the second lowest in TT Immunization (32 percent), again second lowest in taking iron tablets (20 percent) and the lowest percentage of women in U.P. go for BP check-up (9 percent). To be concluded, one can say that womenr's immunization is quite high in the states of Punjab, Haryana and

Himachal Pradesh showing that they are health conscious more than the women of U.P. and Rajasthan.



The above diagram shows that 50 percent Muslim women of various social groups aged 15-49 who received ANC, stand at 5th position while Christians with the highest percentage of more than 80 percent stand 1st position in receiving ANC. Scheduled Tribes about 40 percent of them are at 6th position, which is the lowest. Other minorities is at the second highest with an average percentage of 68 percent, the third highest are Scheduled Caste (58 percent) and Hindus are fourth highest (57 percent). Thus, comparing to other religious communities, Muslim women about 50 percent of them do not received ANC which is a case of serious concern.

REFERENCES

1. Aarzoo, S. S. & Afzal, M. (2006), "Reproductive fitness and selection intensity among Muslims of North India, *Journal of Human Ecology* 19, pp. 107-112

2. Dharmalingam, A. Navaneetham K and Morgan S. P.(2005), "Muslim-Hindu Fertility Differences Evidence from National Family Health Survey-II", *Economic and political Weekly,* Vol. No. , January 29, pp. 429-436

3. G. Ara, Itrat-un-Nisa, Y. Hasan Siddique & M. Afzal (2008), maternal age and Ethnicity in determining Demography and Selection Intensity parameters among North Indian Muslims. *The Internet Journal of Biological Anthropology,* Volume 2 Number 1.

4. Indian Human Development Report (1999).

5. Mudurani, Lakshmipathi, Raju.(ed.), (2007),"Women Empowerment, Challenges and Strategies" Regal Publication, New Delhi,pp. 125-128.

6. National Family Health Survey (2005-06), Vol. 3

7. Padma, Rama, G. (2005), "Perceptions on Safe Motherhood An Analysis of Results from Rural Andhra Pradesh", *Economic and Political Weekly*, Vol.XXIV, No. , January 29, pp. 465-473.

8. Shariff, Abusaleh. (1995), "Socio-Economic and Demographic Differentials between Hindus and Muslims in India", *Economic and Political Weekly*, Vol. 30, No. 46, November 18, pp.2947-2953.

9. Unnithan-Kumar, Maya. (1999), "Households, Kinship and Access to Reproductive Health care among Rural Muslim Women in Jaipur", *Economic and Political Weekly*, Vol. 23, No. 30, March 6-13, pp.621-630.

10. U.S. Bureau of the Census, International Programmes Centre. (1995), HIV/AIDS in Asia, Research Note No.18, Washington, D.C.

11. http://www.sawnet.org/health/abstracts.html

12. http://infochangeindia.org/200212035891/Women/Books-Reports/Muslim-Women-s-Survey.html

13. http://www.google.co.in/search?source=ig&hl=en&rlz=1R2ADFA_enIN341&q=journal+of+human+ecology+2006+s.+arzoo+and+m+afzal+article&btnG=Google+Search&meta=lr%3D&aq=f&oq=

14. http://www.csas.ed.ac.uk/wellcome.php

CHAPTER-4

INTERFACE BETWEEN HEALTH, REPRODUCTIVE HEALTH AND EMPOWERMENT OF MUSLIM WOMEN

The 1994 Cairo Conference on Population and Development (ICPD) focused on the role of women's empowerment in influencing reproductive behavior. However, there is no complete agreement on how this concept should be defined and measured

Since the Cairo and Beijing conferences, as a result of the demands of various women's groups, there has been particular emphasis on the need to examine the degree of men's involvement in family life and in the promotion of their participation in the various stages of socio-biological reproduction (such as the decision to have children, pregnancy, childbirth, post-natal care, and looking after and raising children in general). The absence of men in the analysis of fertility and birth control had been criticized since the mid-1980s from a gender perspective. The role of men in the family, sexuality, and biological reproduction is posited as being crucial, both for the advance of knowledge and for achieving greater equity between men and women.

The empowerment and autonomy of women, and improvements in their political, social, economic and health status, are recognized by the International Conference on Population and Development (ICPD) as highly important ends in themselves. In addition, they are seen as essential for the achievement of sustainable development.

The central role women play in regard to population and development has been strongly emphasized in all preparations for ICPD. Empowerment of women was

discussed during five regional population meetings, three sessions of the ICPD Preparatory Committee, and a number of expert group meetings and round tables.

The draft Programme defines reproductive health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."

Reproductive health implies that people are able to have a satisfying and safe sex life and that they will have the capability to reproduce and the freedom to decide if, when and how often to do so. Women and men must be provided with the necessary information and services to exercise this right, according to the draft Programme.

Muslim women, like most women all over the world suffer similar problems particularly in relation to their sexual and reproductive health rights such as: Maternal mortality and morbidity due to pregnancy and childbirth; contraceptive use,; access to safe, legal abortion; safe, consensual and satisfactory sexual relations; domestic violence and sexual coercion; contraction of STIs and HIV/AIDS.

The Cairo ICPD concept of reproductive health has the following four basic principles:

(1) the right to decide freely on the number and spacing of children, and the right to have the information and means to do so;

(2) the right to attain the highest standard of sexual and reproductive health;

(3) the right to make decisions concerning reproduction free of coercion, discrimination, or violence;

(4) The right to have satisfying and safe sexual relations.

(Islamic Law) articulate the rights of Muslim women to attain a high standard of sexual and reproductive health, and make their own decisions regarding marriage, motherhood, contraception, abortion and sexuality free of coercion, discrimination and violence.

The national sovereignty principle in the ICPD Programme of Action (POA) states that governments can implement the POA but should take into consideration national, cultural and religious circumstances.

At the 1994 Cairo ICPD and the 1995 Fourth World Conference on Women in Beijing, the governments of a number of Muslim countries contended that the rights of Muslim women to equality in marriage and to sexual and reproductive rights were different to that of other women. Their position was women's rights in Islam are incompatible with women's global human rights.

To address these concerns, Muslim human rights and women's rights activists in various parts of the world have put forth alternative understandings of Islamic teachings on sexuality, reproductive health and women's rights which are compatible with universal principles of human rights.

Several strategies and action plans are being utilized for this agenda. Fundamental to these is the development of progressive scholarship in Islam based on gender equality and justice.

Muslims are not monolithic/homogenous in their understanding and practice of Islam

The human rights situation in self-proclaimed Islamic states is more conditioned by culture and traditions than by its purported 'Islamicity'

Islam is compatible with social justice and international standards of human rights(both civil and political rights as well as economic, social and cultural rights)

Strategies for reform call for a paradigm shift in the study and application of Islamic/Muslim Jurisprudence

The diversity within the Muslim world on the issues of social justice and human rights, particularly gender equality, women's rights, sexuality and reproductive health and rights, are reflected in three levels of discourse such as:

I. Interpretation of Islamic texts, as sources of authority and justification for a particular stand or ideology;

II. The level of local/national political ideologies, rhetorics, and debates, with their local historical particularities;

III. The level of lived experiences for any given individual or local community.

Recognizing that discrimination on the basis of gender starts at the earliest stages in life, the document asserts that greater equality for girls in regard to health, nutrition and education is the first step in ensuring that women realize their full potential and become equal partners in development. The draft Programme encourages leaders to speak out forcefully against gender discrimination, and undertake efforts to promote equitable treatment of girls and boys with respect to nutrition, health care, inheritance rights, education, and social, economic and political activity.

The draft Programme of Action underscores the need to promote gender equality in the family and in the community, noting in particular that men should take responsibility for their fertility and parental duties. It calls for special efforts to involve men in safe and responsible parenthood and family planning.

Education is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in the development process. One of the goals specified in the draft Programme of Action is

for all countries to ensure that all girls and boys have access to primary school or equivalent level of education, as quickly as possible and in any case before 2015.

Reproductive health care, the document states, should include: information and services for family planning, prenatal care, delivery and post-natal care; prevention of abortion and management of complications of abortions; healthcare for women and infants; and prevention and treatment of infertility and sexually transmitted diseases; among others.

Though a woman is the key person to provide health services to the family and society, she is neglected and exploited and she is not getting what is due to her. Without good physical and mental health of woman, her economic and political empowerment cannot be achieved. A dispassionate analysis of the factors responsible for her neglect and exploitation is necessary to empower her.

The economic and cultural worth of female is found to be inversely related to the socio-economic status of the family. As females are less useful economically, their worth is low and they receive small share of the family resources in higher strata where as when women were employed in agriculture there were valued much and rate of female mortality is low.

A village level study in U.P. (Khan et. Al.,1988) suggests that even when women were aware of diet during pregnancy, cultural and economic priorities deny them access to better nutrition. Women were anaemic 40-50 percent in urban areas. Anaemia not only leads to death but also to contribute in aggravating complications of pregnancy. In India, for one healthy mother, there are twenty mothers who are suffering from impaired health, i.e. 2.4 million mothers in India are having impaired health as a result of pregnancy the frame work for prevailing gender relations in Indian society. Lack of socialization, ignorance in matter of sexuality, fear and shame regarding their physical structure is making her a subordinate in the family relations.

Early marriage, unprotected sex, unwanted pregnancies; abortions are bringing down her resistance to infection. This background is giving a favourable

environment to infections such as STD and HIV. APSACS estimates 5.67 millions are identified as HIV positive people in India, i.e. one tenth of the World's population affected with HIV. 2 percent of HIV women were found in antenatal clinics. Thus poverty, powerlessness, low social status malnutrition, high fertility and lack of health care is resulting in high reproductive morbidity among women.

Health is both an important factor in the achievement of status as well as an indicator of social status, particularly for women, whose health is conditioned to a great extent by social attitudes. The health status of women includes their mental and social condition as affected by prevailing norms and attitudes of society in addition to their biological and physiological problems. Society delineates women's roles partly according to their biological function and partly from prevailing attitudes regarding their physical and mental capacity.

Women's health status is basic to their advance in all fields of endeavour. Any serious attempt to improve the health of women must deal firstly with biased social customs and cultural traditions that have an impact on their status. Though the health problems of women have been identified for priority attention and efforts made for maternal and child services since the beginning of planned development in India, much remains to be done to improve health care for women both in qualitative and quantitative terms. However in subsequent plan periods it has been observed that resource allocations for health have been decreasing. There is need for a more comprehensive integrated approach to health issues if there is to be a significant impact on the present conditions of Indian women. The cultural norms that specially affect women's health are the attitudes to marriage, age of marriage, the value attached to fertility and sex of the child, the pattern of family organizations and the ideal role demanded.

Nutritional Status of women is a major determinant of the health and development of the community. In developing countries like India the incidence of malnutrition among women is very high. Maternal nutrition is major determinant of interauteine development of foetus and major influence on outcome of pregnancy.

Malnutrition during pregnancy complicated by stunted growth and infections carries high mortality of mothers.

ICMR identified the maternal nutritional risk factors to reduce the maternal death during the course of life.

1. If maternal age is less than 18 years
2. If maternal weight is less than 40 kgs.
3. If height of mother less than 145 cm
4. If weight gain during pregnancy less than 5 kgs.
5. If birth interval is less than 2 years.
6. If body mass index isles than 16.

"The exceptionally high rates of malnutrition in South Asia are rooted deeply in the soil"of inequality between men and women". . .the poor care that is afforded to girls and women by their husbands and by elders is the first major reason for levels of child malnutrition that are markedly higher in South Asia.

"Gender disparities in nutrition are evident from infancy to adulthood. In fact, gender has been the most statistically significant determinant of malnutrition among young children and malnutrition is a frequent direct or underlying cause of death among girls below age 5. Girls are breast-fed less frequently and for shorter durations in infancy; in childhood and adulthood, males are fed first and better. Adult women consume approximately 1,000 fewer calories per day than men according to one estimate from Punjab Comparison of household dietary intake studies in different parts of the country shows that nutritional equity between males and females is lower in northern than in southern states."

Nutritional deprivation has two major consequences for women: they never reach their full growth potential and they suffer anemia. Both are risk factors in pregnancy, with anemia ranging from 40-50 percent in urban areas to 50-70 percent in rural areas. This condition complicates child-bearing and result in maternal and infant deaths, and low birth weight infants (Raju Laxmipathi , 2007,pp. 107-117).

Good health is a human right and a measure of human well being. The right to health care is primarily a claim to an entitlement. The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfill'. Further using a human rights approach also implies that the entitlement is universal. This means there is no exclusion on any grounds the provisions made to assure health care. In 1978, the Alma Ata conference hosted by the WHO promoted the goal of 'health for all by the year 2000'. This concept is based on three elements equal rights to health, community participation and inter-school collaboration.

Gender Development Index (GDI) adjusts the average achievement to reflect the inequalities between men and women in the life expectancy, literacy, enrollment ratio and standard of living measured by earned income (U, Silppa. 2007, p-2).

The health of Indian women is intrinsically linked to their status in society. Women in India from a silent and often invisible group making up nearly half the population. Most of them remain out of reach of even the most basic health care. Women had internalized the ethic of nobility in suffering which emanates from the fact that reproductive and sexual roles are accepted as the very essence of womanhood. Women in poor health are more likely to give birth to low weight infants. They are also less likely to be able to provide food and adequate care for their children. Finally, a women's health affects the household's economic well being, as a woman in poor health will be less productive in the labour force. Poverty and gender, literacy has a direct impact on health and sex ratio, life expectancy at birth, IMR, MMR etc hence they are taken as indicators for addressing women's health.

Maternal mortality and morbidity are two health concerns that are related to high levels of fertility. The maternal mortality ratio which is a measure of the obstetric risk associated with each pregnancy, is estimated to be 400 per 1000 live births globally. For every three deaths of women in their reproductive years in some developing countries, one is the result of complications from pregnancy and childbirth. Nearly 15 percent deaths of women in the reproductive age in India are

maternal deaths of girls are in the 15-19 years age group, which are mainly due to unsafe complications arising out of unsafe abortions (U, Silppa. 2007, pp.3-4).

The underlying causes for maternal mortality are poor health and nutrition, lack of physical access to health care (including transportation and finances), medical causes and socio cultural factors that obstruct the importance of healthcare for women. The cultural practices regarding the restriction of food during pregnancy for fear of difficulties at the time of delivery is prevalent in many parts of the country. Only 52 percent of women are involved in decision making on their own health care.

The HIV/AIDS epidemic in India is spreading rapidly and increasingly affecting women's health in recent years. Out of the total infected 38.45 were females, 57 per cent in rural areas. Within an HIV population that is regarded as vulnerable, women may be considered as more vulnerable. Vulnerability is understood as a limitation of the extent to which one is capable of making and effecting free and informed decisions. Vulnerability can be due to lack o information, education, health, social services and human rights programmes, political, cultural, tradition, gender relations and attitude towards sexuality, religious beliefs and poverty.

The culture of silence that surrounds sex dictates that "good women" are expected to be ignorant about sex and be passive; this makes it difficult for them to be pro-active in negotiating safer sex, and accessing treatment and services for sexually transmitted diseases. Cultural practices such as female genital mutilation, early and forced marriages and sexual practices may contribute to infection (U, Silppa. 2007, -4).

There is growing recognition that that gynaecological morbidity is an alarming health problem among the Indian women. However, information on the level, pattern of the morbidity and the treatment seeking behavior of the women remains sparse. Prior community-based research has found that a large proportion of women suffer gynaecological health problems silently, and are reluctant to seek treatment. Generally women with self-reported symptoms of reproductive morbidity do not seek treatment due to exiting taboos and inhibitions regarding sexual and

reproductive health. They are particularly hesitant to discuss their reproductive health problems due to shame embarrassment. Even if they seek treatment, a majority of women seek health care from unqualified private practitioners or discuss their problem with the elderly women of the family or the village and adopt some home remedies, which in turn may have serious implications on their health.

In a patriarchal society, women's health and access to services cannot be studied in isolation to the role played by their male partners, since women are dependent upon their partners economically, socially and emotionally. This is even more critical in the arena of reproductive health. Since ICPD, Cairo (1994) and fourth World Conference on Women in Beijing, men's role in the reproductive programmes is well recognized and its importance in improving women's health status understood. This has led to a greater emphasis being placed on involving men in RCH programmes. Some studies in India suggest that women's reproductive morbidity is seldom discussed, and addressed only when it interferes either with their childbearing abilities or their ability to work at home. Thus women suffer in silence (Singh,Sampurana, 2007. p-16).

Empowerment is one of the tried and tested strategies for attaining gender equality. There is constitutional mandate to deal with different dimensions of equality for women in India. Constitution clarifies that affirmative action for women is compatible with the principles of non-discrimination on the ground of sex. India has also ratified various international conventions and human rights instruments committing to secure equal rights for women. Women lag behind men in most of the critical indicators of human development and poverty among women is on the rise. Women have a subordinate status in almost every sphere of life. Efforts of the Government, however, primarily revolve around economic empowerment and relatively less in the field of social empowerment.

Social empowerment is about people regaining their own power to shape their lives creatively and to influence the course of events around them – against oppression and exclusion, for democratic participation, peace and human rights. In this context, it is important to discover one's own skills, opportunities and resources,

to develop them, share them with others and to use them to reach one's own aims. It indicators include education, health, housing, human rights etc.

Women are exposed to major health risks due to their reproductive roles. If pregnant women are not well nourished, they are more likely to give birth to underweight babies leading to higher infant mortality rates. It is observed that wherever infant and child mortality is higher, there, the birth rates are also higher. Women are exposed to high maternal mortality rate (MMR) and it is evident from the fact that MMR in India is still 407 per 1, 00,000 live births in 2005. A strong gender bias exists even in the case of access to health care services and quick medical care to the infant girls. Sex specific mortality rate for 0-6 years is higher for the girls.

There was awareness generation through group meetings among women about the significance of nutrition and balanced diet, usage of organic foods, hygienic living, proper usage of toilets and bathrooms to avoid open defecation, importance of clean drinking water, disadvantages of early marriage, information about AIDS, removing superstitions about health etc. (Rizwana, A,2007, pp. 20-21).

Women in India face many serious health concerns, this analysis focuses on only two issues: nutritional status (as measured by body mass index and prevalence of anemia) and reproductive health (as assessed by the presence of reproductive health problems) of women from villages in the study area. Results show that though both work status and socio-economic factors influence health status, the latter are more important; most of the gross effect of work status is due to socio-economic conditions rather than work participation. This calls for policy intervention in providing better health facilities, female education and supplementary nutrition programs for poor women (Basu and Narayan, 2008).

Reproduction often becomes a determinant of the status of women in our society. There is a need to give out health care system from curative to preventive. The World Bank in its recent report pointed out that maternal mortality is very high in India. The World Bank in its report further revealed that there is an excess

maternal morbidity and mortality resulting from physical assaults such as rape, burning, and beating. The abortion-related mortality and morbidity seems to be high especially in the rural areas. The pre-ponderance of illegal unscientific and traditional methods of abortion in rural areas caused a lot of damage to women's health in general and reproductive health in particular.

Maternal mortality refers to deaths due to pregnancy-related causes. The maternal mortality rate is very high in India (437) in 1994. It shows an increasing tendency. The high rate is attributed to unwanted, unplanned pregnancies, malnutrition, lack of regular medical consultation, lack of knowledge of health care, illiteracy, poverty, less access medical care in proper time; women's health in India states that India accounts for almost 25 percent of world's maternal deaths and number of pregnancy-related deaths in rural areas are still highest in the world. The maternal mortality is high in India because of social and economic factors. Most of these deaths are preventable because it is only reflection of women's nutrition, poor health states and high fertility, poor access to utilization of health seminars, etc. The accessibility and availability of health provides is one of the important factors that determine maternal mortality.

The age of marriage is very low in India. Universality of marriage and child marriages are very much prevalent in India. Even though Sarada Act was passed as early as 1929 with a view to eliminate child marriages and uplift the dignity of women, still 50 percent of the women in the country is getting married less than the legal age of marriage. The prevalence of spinstership is very less in India since it is associated with social stigma.

Early child bearing is associated with high risk of pregnancy since women will not attain proper physical and mental maturity by that time. Spontaneous abortions, foetal deaths are very high among women getting married early. The prevalence of primary sterility is also very high among women marrying below 18 years age. Early child bearing is one of the reasons for high maternal mortality in the country.

Infant mortality is considered to be a fairly sensitive index of the health of the health condition of population in a society; it is affected by both biological and environmental factors. Apart from genetic factors, the age of the mother, order of birth, spacing of children play a very significant role in determining the level of infant mortality in society.

Women bear gigantic share of family planning burden especially in the rural India. The complications arising after tubectomy and IUD and side effects of oral pills have further shaked the health of the rural women. Male members are not coming forward to share the burden of family planning. There is a myth and fear among people that men will become important by undergoing vasectomy operation. That is most of women alone are undergoing family planning operations. Due to poverty some women are becoming victims of STD, TB, Goiter, etc. Thus, women's health is affected finally leading to low sex ratio in the country.

Women are discriminated against men historically in terms of education, health and social justice. Education plays a crucial role in improving the possibilities for personal growth. Similarly, cultural norms, values and customs are no less important in determining the women's life choices and physical and mental well being. The linkages between the culture, women's education and health are important to improve the status of women in the society. Thus, all these factors put together has led to gender inequality in India. There is a need to empower the women in India by bringing changes in the reproductive health of women. Also there is a need to empower the women through social, economic and political measures (Mudurani, Laxmipathi, Raju, 2007, pp. 49-62).

Early marriage is considered a health hazard both for the child as well as the mother. The mean age at marriage for female no doubt increased from 13.1 to 18.3 during 1901-1981. But still this falls short of the ideal age of the child bearing period, i.e. 20 to 35. What is more is there are many states falling short of the national average of 18-32 years in 1981. In Rajasthan it is 16.9, Madhya Pradesh 16.52, Uttar Pradesh 17.17. Andhra Pradesh also falls of the national average. There are in sharp contrast to Kerala where its 21.85 years. There has been a decline in the percentage

of girls getting married in their teens. But as per 1981 data still seven percent of the girls in the age group of 10-14 are 43 percent. In the age group of 15-19years was already married. Early marriages, short birth intervals and higher pregnancies and the synergistic interaction, effects of malnutrition, uncontrolled fertility creates health hazards(Mudurani, Laxmipathi, Raju, 2007, pp. 120-121).

Women's empowerment means that women no matter where they are, healthy, have enough for their needs, their own survival and that of their family and community, to be able to live with dignity, live and work in safe and caring environment, which allows their growth and holistic development, i.e., physically, emotionally, socially, economically. Women's empowerment means that they can take decisions about their life, their children and family also contribute to the community decisions, where women's right 'personhood', 'bodily integrity' is respected where their reproductive rights, social, economic and political rights are respected, i.e. their work and contribution to the family, society is recognized, where there is no fear of sexual and social violence, where women feel a senses of acceptance and belonging, where their right to their home and to their children as guardians is respected.

There is a need to challenge patriarchal policies, behaviour, and attitudes to control decision making, resource use to deny and freedom to think, act and live differently even marginally.

The year 2001 is the year of Women's Empowerment. The last decade saw ICPD, Cairo, Beijing Conference, Social Summit, Copenhagen, Human Rights, Vienna. There is no denying that in some areas women have been given opportunities, which they have well utilized, e.g., in terms of education and opportunities. Yet the fact remains that as women are shouldering home, fulfilling their reproductive roles as well as work responsibilities outside, besides caring for in-laws, children, animals etc. the changes in male behaviour, in terms of helping in child care, house work, has not happened. Even women have also become 'bread winners' as well as 'Roti makers' their burden has undoubtedly only increased with little or no help from the spouses.

There have been tremendous gains in the last 50 years where health of the women is concerned as small pox and guinea worm was wiped out, deaths from Malaria decreased, infant mortality and maternal mortality decreased, and life expectancy of women increased.

The Constitution of India in its preamble stated that –we, the people of India . . . . hereby adopt, enact and give to ourselves this Constitution . . . .

Duty of the State to raise the level of the nutrition and the standard of living and to improve public health.

The State shall regard the raising of the level of nutrition and the standard of its people and in particular the State shall endeavour to bring about prohibition of the consumption, except for medical purposes, of intoxicating drinks or drugs which are injurious to health.

The Bhore Committee which was set up in 1940 and submitted its comprehensive proposal for a nutritional health programme of health services in 1946, i.e., pre-independence stated that:

The Committee strongly advocated integration of preventive and curative care at all administration levels. Formation of village health committees, district health boards, development of social physicians with inclusion of 3 months of social preventive medicine in medical education to produce appropriate health care personnel, development of primary health centres with integrated approach to health service development. It was for the first time that a comprehensive national health programme had been put forward.

The health of the Women in India, as anywhere else is dependent in their social status, their capacity to meet basic needs, their working and living conditions and the health of their family and community.

The Alma Ata Charter of 1978 proposed Health for All with priority given to comprehensive primary health care – recognizing the socio-economic and political

roots of ill health and also recognizing that it is the poor and the vulnerable women, children who needed priority.

In 1981 the ICMR-ICSSR joint panel on health came out with 'alternative strategies – Health for All' (Kapur, Promilla, 2001, pp.126-129).

The principle of gender equality is enshrined in the Indian Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favour of women.

Within the framework of a democratic polity, our laws, development policies, Plans and programmes have aimed at women's advancement in different spheres. From the Fifth Five Year Plan (1974-78) onwards has been a marked shift in the approach to women's issues from welfare to development. In recent years, the empowerment of women has been recognized as the central issue in determining the status of women. The National Commission for Women was set up by an Act of Parliament in 1990 to safeguard the rights and legal entitlements of women. The 73rd and 74th Amendments (1993) to the Constitution of India have provided for reservation of seats in the local bodies of Panchayats and Municipalities for women, laying a strong foundation for their participation in decision making at the local levels.

India has also ratified various international conventions and human rights instruments committing to secure equal rights of women. Key among them is the ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993.

The Mexico Plan of Action (1975), the Nairobi Forward Looking Strategies (1985), the Beijing Declaration as well as the Platform for Action (1995) and the Outcome Document adopted by the UNGA Session on Gender Equality and Development & Peace for the 21st century, titled "Further actions and initiatives to

implement the Beijing Declaration and the Platform for Action" have been unreservedly endorsed by India for appropriate follow up.

The Policy also takes note of the commitments of the Ninth Five Year Plan and the other Sectoral Policies relating to empowerment of Women.

The women's movement and a wide-spread network of non-Government Organisations which have strong grass-roots presence and deep insight into women's concerns have contributed in inspiring initiatives for the empowerment of women.

However, there still exists a wide gap between the goals enunciated in the Constitution, legislation, policies, plans, programmes, and related mechanisms on the one hand and the situational reality of the status of women in India, on the other. This has been analyzed extensively in the Report of the Committee on the Status of Women in India, "Towards Equality", 1974 and highlighted in the National Perspective Plan for Women, 1988-2000, the Shramshakti Report, 1988 and the Platform for Action, Five Years After- An assessment"

Gender disparity manifests itself in various forms, the most obvious being the trend of continuously declining female ratio in the population in the last few decades. Social stereotyping and violence at the domestic and societal levels are some of the other manifestations. Discrimination against girl children, adolescent girls and women persists in parts of the country.

The underlying causes of gender inequality are related to social and economic structure, which is based on informal and formal norms, and practices.

Consequently, the access of women particularly those belonging to weaker sections including Scheduled Castes/Scheduled Tribes/ Other backward Classes and minorities, majority of whom are in the rural areas and in the informal, unorganized sector – to education, health and productive resources, among others, is inadequate. Therefore, they remain largely marginalized, poor and socially excluded.

Women's equality in power sharing and active participation in decision making, including decision making in political process at all levels will be ensured for the achievement of the goals of empowerment. All measures will be taken to guarantee women equal access to and full participation in decision making bodies at every level, including the legislative, executive, judicial, corporate, statutory bodies, as also the advisory Commissions, Committees, Boards, and Trusts etc. Affirmative action such as reservations/quotas, including in higher legislative bodies, will be considered whenever necessary on a time bound basis. Women–friendly personnel policies will also be drawn up to encourage women to participate effectively in the developmental process.

A holistic approach to women's health which includes both nutrition and health services will be adopted and special attention will be given to the needs of women and the girl at all stages of the life cycle. The reduction of infant mortality and maternal mortality, which are sensitive indicators of human development, is a priority concern. This policy reiterates the national demographic goals for Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) set out in the National Population Policy 2000. Women should have access to comprehensive, affordable and quality health care. Measures will be adopted that take into account the reproductive rights of women to enable them to exercise informed choices, their vulnerability to sexual and health problems together with endemic, infectious and communicable diseases such as malaria, TB, and water borne diseases as well as hypertension and cardio-pulmonary diseases. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases will be tackled from a gender perspective.

To effectively meet problems of infant and maternal mortality, and early marriage the availability of good and accurate data at micro level on deaths, birth and marriages is required. Strict implementation of registration of births and deaths would be ensured and registration of marriages would be made compulsory.

In accordance with the commitment of the National Population Policy (2000) to population stabilization, this Policy recognizes the critical need of men and

women to have access to safe, effective and affordable methods of family planning of their choice and the need to suitably address the issues of early marriages and spacing of children. Interventions such as spread of education, compulsory registration of marriage and special programmes like BSY should impact on delaying the age of marriage so that by 2010 child marriages are eliminated.

Women's traditional knowledge about health care and nutrition will be recognized through proper documentation and its use will be encouraged. The use of Indian and alternative systems of medicine will be enhanced within the framework of overall health infrastructure available for women.

In view of the high risk of malnutrition and disease that women face at all the three critical stages viz., infancy and childhood, adolescent and reproductive phase, focussed attention would be paid to meeting the nutritional needs of women at all stages of the life cycle. This is also important in view of the critical link between the health of adolescent girls, pregnant and lactating women with the health of infant and young children. Special efforts will be made to tackle the problem of macro and micro nutrient deficiencies especially amongst pregnant and lactating women as it leads to various diseases and disabilities.

Intra-household discrimination in nutritional matters vis-à-vis girls and women will be sought to be ended through appropriate strategies. Widespread use of nutrition education would be made to address the issues of intra-household imbalances in nutrition and the special needs of pregnant and lactating women. Women's participation will also be ensured in the planning, superintendence and delivery of the system.

All forms of violence against women, physical and mental, whether at domestic or societal levels, including those arising from customs, traditions or accepted practices shall be dealt with effectively with a view to eliminate its incidence. Institutions and mechanisms/schemes for assistance will be created and strengthened for prevention of such violence, including sexual harassment at work place and customs like dowry; for the rehabilitation of the victims of violence and for

taking effective action against the perpetrators of such violence. A special emphasis will also be laid on programmes and measures to deal with trafficking in women and girls.

All forms of discrimination against the girl child and violation of her rights shall be eliminated by undertaking strong measures both preventive and punitive within and outside the family. These would relate specifically to strict enforcement of laws against prenatal sex selection and the practices of female foeticide, female infanticide, child marriage, child abuse and child prostitution etc. Removal of discrimination in the treatment of the girl child within the family and outside and projection of a positive image of the girl child will be actively fostered. There will be special emphasis on the needs of the girl child and earmarking of substantial investments in the areas relating to food and nutrition, health and education, and in vocational education. In implementing programmes for eliminating child labour, there will be a special focus on girl children.

The draft Programme of Action, "Health, Morbidity and Mortality", deals with: primary health care and the health-care sector; child survival and health; women's health and [safe motherhood]; and HIV infection and AIDS.

The draft Programme presents a comprehensive set of mortality-reduction goals, calling particular attention to the need to reduce infant and child mortality and maternal mortality. It states that one of the aims of Governments should be to eliminate excess mortality of girls, wherever such a pattern exists. It underscores the need to achieve a rapid and substantial reduction of maternal morbidity and mortality. The realization of these goals will have different implications for countries with different levels of mortality. However, all countries are called upon to reduce maternal morbidity and mortality levels to where they no longer constitute a public health problem. (Cairo Conference)

The age at which women begin or stop child-bearing, the intervals between births, the total number of pregnancies and the socio cultural and

economic circumstances in which women live all influence maternal morbidity and mortality.

REFERENCES

1. Barua, A. and Pande, R. (2004), "Caring Men? Husbands' Involvement in Maternal care of Young Wves", *Economic and Political Weekly,* December 25, pp-5667

2. Basu, Sharmistha and sidh, Shiv, Narayan. (2008), *World Health Population,* Vol. 10, No. 2, p-1.

3. International Conference on Population and Development. (1994), *Women Empowerment and Health,* Cairo, Egypt

4. Kapur, Promilla.(ed.) (2001), Empowering the Indian Women, Publication Division, New Delhi.

5. Mudurani, Lakshmipathi, Raju.(ed.), (2007*),Women Empowerment, Challenges and Strategies,* Regal Publication, New Delhi, pp.49-121

6. Rizwana, A. (2007), "Health Intervention for Women's Empowerment: A Case Study of Sitapur District (UP)", *Women's Link,* Vol. 13, No. 4,pp. 20-23

7. Silppa, U. J. (2007), "Women and Health for All- A Retrospective Analysis", *Women's Link,* Vol. 13, No. 4, October-December, pp. 2-5

8. Singh, Sampurana. And Ram, F. (2007), " Husbands'Support to Wives in Accessing Reproductive Health Services: A Gender Perspective from Rural India", Women's Link, Vol.13, No. 4, pp. 16-19.

9. http://mail.sarai.net/pipermail/reader-list/2007-June/009478.html

10. http://www.pngoc.com/content.php?r=&c=66

11. http://www.wcd.nic.in/empwomen.htm

BIBLIOGRAPHY

Aarzoo, S. S. & Afzal, M. (2006), "Reproductive fitness and selection intensity among Muslims of North India, Journal of Human Ecology 19, pp. 107-112

Agarwal, Bina. (2002),"Gender Land and Livelihood", in Mohanty, Bidyut. (ed.), *Women Political Empowerment 2000,* New Delhi, Institute of Social Sciences.

Ahmad, Aijazuddin. (1996),"*Muslims in India*", New Delhi, Inter India Publication, pp. 39-40.

Akande, Jade O. and Priscilla O. Kuye. (1986), "Nigeri: Family Law Project", In Margaret Schuler (ed.), Empowerment and the Law: Strategies of Third World Women, Washington D.C.: OEF International, pp.335-41

Akram, Mohd. (ed.) (2007), *Health Dynamics and Marginalized Communities,* Rawat Publication, Jaipur.

Akthar, Rais. (1982), *The Geography of Health,* Manohar Publcations, New Delhi.

Annand, Mily. Roy (2005), "Conceptualizing Empowei ment in the context of Women and Development", *Roshnii.*

Ansari, Anis. (1992), "Educational Backwardness of Muslims", Economic and Political Weekly, Vol. 27, No.42, October 17, pp 2289-91

Ansari, Iabal,A. (2006),*PoliticalRepresentation of Muslims of India: 1952-2004*, Manak, Delhi

Barua, A. and Pande, R. (2004), "Caring Men? Husbands' Involvement in Maternal care of Young Wves", Economic and Political Weekly, December 25, pp-5667

Basu, Sharmistha and sidh, Shiv, Narayan. (2008), World Health Population, Vol. 10, No. 2, p-1.

Batliwala, Shrilatha. (1994), "The Meaning of Women's Empowerment; New Concepts for Action" in G Sen, A.Germain LC Chen. (ed.), *Population Policies Reconsidered: Health, Empowerment and Right,* Hayard University Press.

Batliwala, Shrilatha. (1995), "Empowerment of Women in South Asia", quoted in Raj, S., Ravi, V., and Latha,H.M. (2006)

Behera, Kumar, Deepak and Indira, R.(1999), *Gender and Society in India*, Manak Publications, New Delhi.

Bhasin, Kamala. (1971), *The Position of Women in India*, Deshpande Publishing, Bombay.

Bhatnagar, G, S. (1972), *Education and Social Change*, The Minerva Associates, Calcutta.

Bossert,T., Beauvias, J., Bowser, D. (2000), "Decentralization of Health Systems: Preliminary Review of Four country case studies", *Partnerships for Health Reform*, Bethesda Maryland.

Carr, M.,Chen, M. and Jabvala,R. (1996), *Speaking out: Women's Economic Empowerment in South Asia*, IT Publications, London.

Chakarbarti, Debashis. (1995), "Harbinger of Reforms", The Pioneer, New Delhi, p.9

Chanana, Karuna. (1988), *Socialization, Education and Women Explorations in Gender Identity*. Orient Longman Press, New Delhi.

Chatkara, M, C. (2001), *Women and Social Transformation*, A.P.H., Publishing Corporation, New Delhi.

Chatterjee, Meera, (1990), Indian Women: Their Health and Economic Productivity, World Bank Discussion Papers 109, Washington, DC.

Chaturvedi, Archna (2004), *"Muslim women and society"*, New Delhi Common wealth Publisher, pp.1-2.

Christine, Overall. (1987), *Ethics and Human Reproduction*, Allan and Unwin Publications, London.

Crew. (1965). Health its Nature and Conservation, Pergamon press, London.

Delamont, Sara. (2001), *Unchanging Men, Unchanging Women Sociological Perspective on Gender in a Post industrial Society*, Open University Press, Buckingham.

Desai, Neera. (1987), *Women and Society*, Anita Publishers, New Delhi.

Desouza, Alfred. (ed.), (1975), *Women in Contemporary India*, Manohar Publications, New Delhi.

Devendra, kiran. (1994), *Changing Status of Women in India*, Vikas Publishing House, New Delhi.

Dutt, Suresh. (1997), *Women and Development*, Anmol Publication, New Delhi.

Engineer, Asghar, Ali.(2003),*Muslim Minority (Continuity and Change*, Gyan Publishing House, New Delhi, p. 149

Everett, Janamatson. (1981), *Women and Social Change in India*, Heritage Publishers, New Delhi.

Ganeshmurthy V.,S.(ed.),(2008), *Empowerment of Women in India (Social, Economic and political)*, New Century Publications, New Delhi.

Ghosh, Jayati. (2004)," Mu

slims Women in India", Frontline, Vol.21, Issue-19, September 17Giri, V, Mohini. (1998), *Emancipation and Empowerment of Women*, Gyan Publishing House, New Delhi.

Goel, Aruna. (2004), *Organization and Structure of Women Development and Empowerment,* Deep and Deep Publication PVT. LTD. New Delhi.

Goel, Aruna. (2004), *Violence and Protective Measures for Women development and Empowerment,* Deep and Deep Publication PVT. LTD. New Delhi.

Gopalan. Sarala (2002), *Towards Equality – The Unfinished Agenda – Status of Women in India, 2001*, National Commission for Women, New Delhi.

Gulati, S, C. and Rama, Patnaik. (1996), *Womens Status and Reproductive Health Rights*, Har Anand Publications, New Delhi.

Gupta, Amit, Kumar. (1986), *Women and Society: The Development perspective,* Criterion Publishers, New Delhi.

Haise, Lori, L. (1994), "Violence against Women; The Hidden Health Burden", *Word Bank Discussion papers* 225, Washington, DC.

Hardee, et al. "Reproductive Health Policies and Programs In Eight Countries: Progress Since Cairo," International Family Planning Perspectives, 1999: 25 (Supplement): S2- S9.

Hasan, Zoya & Menon, Ritu. (2005), *Unequal Citizen*, Oxford University Press, New Delhi,

India Planning Commmission. (2000), "Women in India Statistical Profile: A Comparative Picture of the Status of Women and Men", *Data Sheet*. New Delhi.

International conference on population and development, (1994) , *Women, empowerment and health,* Cairo, Egypt

Isiugo, Abanihe, Ifeoma M. (1996)," Education and Women's Empowerment", in L. Erinosho, B. Osotimehin and J.E. Olawoye (ed.), *Women's Empowerment and Reproductive Health*, Ibadan, Social Science and Reproductive Health Research Network.

Jayapolan, N. (2000), *Womens Studies*, Atlantic Publishing and Distributors, New Delhi.

Jayapolan, N. (2001), *Women and Human Rights*, Atlantic Publishing and Distributors, New Delhi.

Jejeebhoy, S, J. (1995), *Women's Education, Autonomy, and Reproductive Behaviour: Experience from Developing Countries*, Oxford Calrendon Press, London.

Jejeebhoy, Shireen, J., and Saumya, Rama, Rao. (1995), "Unsafe Motherhood: A Review of Reproductive Health," in Monica Das Gupta, Lincoln, C., Chen and Krishnan, T. N., (edd.), Women's Health in India: Risk and Vulnerability, Bombay.

Kabeer, N. (1990), 'Gender Development and Training: Rising Awareness In Development Planning", GAADU Newspack No. 14.

Kalabagh, Chetana. (1992), *Social and Economic Dimensions of Women's Development,* Discovery Publishing House, New Delhi

Kapur, Promilla. (ed.), (2001), *Empowering the Indian Women*, The Director, Publication Division, New Delhi

Khalidi, Omar. (1995) , *Indian Muslims Since Independence*, New Delhi, Vikas Publication, pp-2

Khan, M, E. and Gupta, R, B. (1985), *Determinants of High Family Plannning and Practices*, Himalayan Publishing House, New Delhi.

Khana, S, K. (1998), *Women and Human Rights*, Common Wealth Publishers, New Delhi.

Kumar, Raj, Devi, Rameshwari and Pruthi, Romila. (1999), *Encyclopedia of Status and Empowerment in India*, Prithi Publications, Jaipur.

Kumari, Ranjana. (1992), *Women in Decision Making*, Vikas Publishing House, New Delhi.

Last J. M. (1983). A Dictionary of Epidemiology, Oxford University Press.

Malhotra, Meenakshi. (ed.), (2004), *Empowerment of Women, Delhi,* Isha Books.

Mehta S. R., (1992), Society and Health, Vikas Publishing House.

Menon, L. (1998), *Women Empowerment and Challenge of Change*, Kanishka Publishers,New Delhi.

Miller, D, Barbara. (1997), *The Endangered Sex: Neglect of Female Children in Rural North India*, Oxford University Press, Chennai.

Mitra, Jyoti. (1997), *Women and Society: Equality and Empowerment*, Kanishka Publishers, New Delhi.

Molyneux, M. (1985), "Mobilization without Emancipation: Women's Interests. State and Revolution in Nicaragua" in D. Slater, (ed.), *New Social Movements and the State in Latin America Amsterdam*, CEDLA Publications.

Moser, M. (1989), "Gender planning in the Third World: Meeting Practical and Strategic Gender Needs", World Development, pp. 17.

Mudurani, Lakshmipathi, Raju.(ed.), (2007),"Women Empowerment, Challenges and Strategies" Regal Publication, New Delhi,

Murthy, K, Ranjini. (2001), *Building Women's Capacities: Introduction in Gender Transformation*, Sage Publications, New Delhi.

Nanda, P. "Studies on the Implications of Health Sector Reforms for Reproductive Health and Rights in India and Tanzania: An update on Current Research Efforts". The Center for Health and Gender Equity (CHANGEO, June 2002.

Napasari, Jayapalan. (2000), *Women Studies,* Atlantic Publishers and Distributors, New Delhi.

Narasima, Sakuntala. (1999), *Empowering Women*, Sage Publications, New Delhi.

Narwani, G.S. (2002). "Training for Rural Development", Rawat publication, New Delhi

Narwani, G.S. (2002*). Training for Rural Development*, New Delhi, Rawat Publication.

Noopur, Indira, Kulshetra. (1999), *Women in Search of Identity*, B.R. Publishing Corporation, Delhi.

Odejide, A. F. (1990), "Appropriate Strategies for Improving Women's Participation in the Rural Industrialization Process", paper presented at the national workshop on women in development sponsored by the National Center for Economic Management and Administration (NCEMA0 held at the Premier Hotel, Ibadan on 28 January-2 February

Padma, Rama, G. (2005), "Perceptions on Safe Motherhood An Analysis of Results from Rural Andhra Pradesh", *Economic and Political Weekly*, Vol. XL, No.5 , January 29, pp. 465-473.

Panda, Snelatha. (1992), *Women and Social Change in India*, Ashish Publishing House, New Delhi.

Pandian, Punithavathy and Eswaran, R. (2002), Empowerment of women through Micro-credit, *Yojana,* Vol. 46, pp. 47-50

Pandya, Rameshwari.(ed.), (2008), *Women Welfare & Empowerment in India*, New Delhi, New Century Publication

Parashar, Archana. (1992), *Women and Family Law Reform in India*, Sage Publications, New Delhi.

Park, k. (2005), *Preventive and Social Medicine*, Jabalpur, M/s Banarsidas Bhanot Publication.

Patel, Krishna, Ahooja. (1995), *Women and Sustainable Development: An International Dimension*, Ashish Publishing House, New Delhi.

Patel, Vibuthi. (2002), *Womens challenge of the New Millenium*, Gyan Publishing House, New Delhi.

Pathak, Rashmi. (2003*), Empowerment and Social Governance*, Isha Books, New Delhi.

Patnaik,Rama and Gulati, S, C. (1998), *Women's Status and Reproductive Health Rights*, Har Anand Publications, New Delhi.

Presser, Hariet, Sen Gita.(2000), *Women's Empowerment and Demographic Process*, Oxford University Press, Oxford.

Pruthi, Raj. And Sharma, Bela, Rani. (1995), *Women and Social Change*, Anmol Publications, New Delhi.

Rao, N, J, Usha. (1983), *Women in Developing Society*, Ashish Publishing House, New Delhi.

Rao, R.K. (ed.) (2000), *Women in Education*, Delhi, Kalpaz Publications.

Rehman, Zainab. (2005), "Women and Society", New Delhi, Kalpaz Publication, pp.81.

Rizwana, A. (2007), "Health Intervention for Women's Empowerment: A Case Study of Sitapur District (UP)", Women's Link, Vol. 13, No. 4,pp. 20-23

Sahay, Sushma.(1998), *Women and Empowerment (Approaches And Strategies),* Discovery publishing house, New Delhi.

Savitri, R. and Mukhopadhay, Swapna. (1998), *Poverty, Gender, Reproductive Choice: An Analysis of Linkages*, Manohar Publications New Delhi.

Serageldian, Ismail. (1991), "culture: Empowerment and the Development Paradigm" *Development I*

Shah, Giriraj. (1995*), The Encyclopedia of Women's Studies*, Gyan Publishing House, New Delhi.

Shanti, K. (1998), *Empowerment of Women*, Anmol Publications, New Delhi.

Sharma, Priyanka.(2008), "Womens empowerment and working women", Book *Enclave, Jaipur.*

Sinha, Debotosh. (2006), "Empowering Women: A Catalyst in Social Development" in Reddy, kumar and Nalini (ed.) Women in Development: Challenges & Achievments, Serials publication,Delhi

Srinivasan, Viji. (1993), *Indian Women,* Har Anand Publications, New Delhi.

Thapan, Meenakshi. (1999), *Embodiment Essays on Gender and Identity*, Oxford University Press, Oxford

Udgebe, I. Bola. (1996), "Empowerment: A Historical and Conceptual Analysis", in L. Erionsho, B. Ostimehin and J.E. Olawoye (ed.), Women's Empowerment and Reproductive Health, Ibadan, Social Science and Reproductive Health Research Network.

Usha, Nayar. And Dutt, Sarala. (2004*), Situational Analysis of Women in the State of Uttar Pradesh*, National Commission for Women, New Delhi.

ARTICLES & JOURNALS

Aarzoo, S. S. & Afzal, M. (2006), "Reproductive fitness and selection intensity among Muslims of North India, Journal of Human Ecology 19, pp. 107-112

Ansari, Anis. (1992), "Educational Backwardness of Muslims", Economic and Political Weekly, Vol. 27, No.42, October 17, pp 2289-91

Barua, A. and Pande, R. (2004), "Caring Men? Husbands' Involvement in Maternal care of Young Wves", *Economic and Political Weekly,* December 25, pp-5667

Basu, Sharmistha and sidh, Shiv, Narayan. (2008*), World Health Population,* Vol. 10, No. 2, p-1.

Bose, Ashish. (2001), "Census of India and After", Economic and Political Weekly, Vol. XXXVI, No.20, May 19, pp. 1685-87

Dharmalingam, A. Navaneetham K and Morgan S. P.(2005), "Muslim-Hindu Fertility Differences Evidence from National Family Health Survey-II", *Economic and political Weekly,* Vol. XL No .5 , January 29, pp. 429-436

Fazalbhoy, Nasreen. (1997), "Sociology of Muslims in India", *Economic and Political Weekly,* Vol.XXXII, No. 26, June 28, pp. 1547-1551.

G. Ara, Itrat-un-Nisa, Y. Hasan Siddique & M. Afzal (2008), Maternal age and Ethnicity in determining Demography and Selection Intensity parameters among North Indian Muslims . *The Internet Journal of Biological Anthropology,* Volume 2 Number 1.

Gandhian. (2000), "Position of Women", *Yojana*, Vol. 44, No. 10.

Ghosh, Jayati. (2004)."Muslim Women in India", Frontline, Vol. 21, Issue-19, publisher, The Hindu.

Health care among Rural Muslim Women in Jaipur", *Economic and Political Weekly,* Vol. 23, No. 30, March 6-13, pp.621-630.

Kabeer,N. (2000), "Inter-generational contracts, demographic transitions and the 'quantity-quality' trade off: Parents and investing in the future", *Journal of International Development,* 12/4, pp.463-482

McDonald, P. (2000), "Gender equity in theories of transition", *Population and Development Review,* 26/3, pp.427-439

Mita, R. and R, Simmons. (1995), "Diffusion of the culture of contraception: Program effects on young women in rural Bangladesh", *Studies in Family Planning*, Vol. 26, No.1, pp. 1-13

Montgomery, M, R. (2000), "Perceiving mortality decline", *Population and Development Review,* Vol. 26, No.4, pp. 795-819

Moser, M. (1989), "Gender Planning in the Third World: Meeting Practical and Strategic Gender Needs", *World Development*

Padma, Rama, G. (2005), "Perceptions on Safe Motherhood An Analysis of Results from Rural Andhra Pradesh", *Economic and Political Weekly,* Vol. XL, No.5 , January 29, pp. 465-473.

Pandian, Punithavathy and Eswaran, R. (2002), Empowerment of women through Micro-credit, Yojana, Vol. 46, pp. 47-50

Rizwana, A. (2007), "Health Intervention for Women's Empowerment: A Case Study of Sitapur District (UP)", *Women's Link,* Vol. 13, No. 4,pp. 20-23

Saguna, B. (2002), "Strategies for Empowerment of Rural Women", *Social Welfare,* Vol. 49, No.5, pp.3-6

Serageldian, Ismail. (1991), "culture: Empowerment and the Development Paradigm" Development I

Seregeldian, Ismail. (1991), "Culture: Empowerment and the Development Paradigm", *Development I.*

Shariff, Abusaleh. (1995), "Socio-Economic and Demographic Differentials between Hindus and Muslims in India", *Economic and Political Weekly*, Vol. 30, No. 46, November 18, pp.2947-2953

Shariff, Abusaleh. (1995), "Socio-Economic and Demographic Differentials between Hindus and Muslims in India", *Economic and Political Weekly*, Vol. 30, No. 46, November 18, pp.2947-2953.

Sharma, S.L. (2000), "Empowerment without Antagonism: A case for Reformation of Women's Empowerment Approach", *Sociological Bulletin*, Vol. 49, No.1, March

Silppa, U. J. (2007), "Women and Health for All- A Retrospective Analysis", *Women's Link,* Vol. 13, No. 4, October-December, pp. 2-5

Singh, Sampurana. And Ram, F. (2007), " Husbands'Support to Wives in Accessing Reproductive Health Services: A Gender Perspective from Rural India", *Women's Link,* Vol.13, No. 4, pp. 16-19.

U.S. Bureau of the Census, International Programmes Centre. (1995), HIV/AIDS in Asia, Research Note No.18, Washington, D.C.

Unnithan-Kumar, Maya. (1999), "Households, Kinship and Access to Reproductive

Yadavendu, Vijay, Kumar. (2003), "Changing Perspectives in Public Health: From Population to an individual", , Economic and Political Weekly, Vol. XXXVII, No.49, pp. 5180

REPORTS

National Family Health Survey. (2005-06), Vol.3.

Sachar Committee Report

India: Human Development Report. (1999)

Committee on the Status of Women.(1974), Towards Equality, Government of India, New Delhi.

WEBSITES

www.kumj.com.np/past/Vol1/issue4/294.pdf

www.un.org/esa/.../complelingfertility/RevisedCosio-Zavalapaper.PDF

http://www.cpdsindia.org/southasianhumansecuritywatch3ed.htm

http://www.macroscan.com/the/employment/sep04/emp170904Muslim_Women.htm

http://www.sawnet.org/health/abstracts.html

http://infochangeindia.org/200212035891/Women/Books-Reports/Muslim-Women-s-Survey.html

http://www.google.co.in/search?source=ig&hl=en&rlz=1R2ADFA_enIN341&q=journal+of+human+ecology+2006+s.+arzoo+and+m+afzal+article&btnG=Google+Search&meta=lr%3D&aq=f&oq=

http://www.csas.ed.ac.uk/wellcome.php

http://mail.sarai.net/pipermail/reader-list/2007-June/009478.html

http://www.pngoc.com/content.php?r=&c=66

http://www.wcd.nic.in/empwomen.htm

http://ijg.sagepub.com/cgi/pdf_extract/14/2/285

http://www.indianmuslims.info/articles/abusaleh_shariff/state_strategy_for_development_and_welfare_of_muslims_in_india.html

http://www.islamweb.net/ver2/archive/article.php?lang=E&id=136100http://www.islamweb.net/ver2/archive/article.php?lang=E&id=136100